Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Yvonne B. Burke
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Bruce A. Chernof, MD
Director and Chief Medical Officer

John R. Cochran III
Chief Deputy Director

Robert G. Splawn, MD
Senior Medical Officer

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

To improve health through leadership, service and education

www.ladhs.org

January 30, 2007

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF TRAUMA CENTER SERVICE AGREEMENTS AND RELATED FUNDING, TRAUMA CENTER/BASE HOSPITAL FEE, TRAUMA CENTER SERVICE AUGMENTATION AGREEMENT AMENDMENT WITH ST. FRANCIS MEDICAL CENTER, AND APPROPRIATION ADJUSTMENT
(All Districts) (4 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Health Services, or his designee, to sign the form Trauma Center Service Agreement (TCSA), substantially similar to Exhibit I, including Exhibits A through F, following signature by officials of authorized representatives of the eleven non-County trauma centers listed in Attachment B, effective retroactive to July 1, 2006 through June 30, 2008, with a signing deadline of February 28, 2007, for each hospital, in order to maintain the Los Angeles County Trauma Center System.

2. Approve funding for the TCSAs to non-County trauma centers for care provided to eligible trauma patients, at the rates set forth in Exhibit B, up to annual maximum amounts of $12.1 million for claims-based payments, $16.7 million for periodic lump-sum payments for providing continued access to emergency care for Medi-Cal beneficiaries, and $2.4 million in recognition of the special costs incurred for those trauma centers providing base hospital services, for a total annual amount not to exceed $31.2 million, for a total two-year agreement obligation not to exceed $62.4 million. A maximum amount of $18.0 million of those funds shall be used annually as an intergovernmental transfer (IGT) for payment to the State to draw-down Medi-Cal matching funds (Federal Financial Participation) and provide the non-County trauma centers, excluding UCLA Medical Center, with an additional $18.0 million annual reimbursement for trauma care.

3. Establish the annual Trauma Center/Base Hospital fee for the non-County and County trauma centers listed in Attachment B to offset the County costs associated with data collection, monitoring, and evaluation for Fiscal Years (FYs) 2006-07 and 2007-08 at $45,470 and $46,230, respectively, for each Contractor, excluding Childrens Hospital Los Angeles. The base hospital requirement does not apply to Childrens Hospital Los Angeles; therefore, the annual Trauma Center fee for Childrens Hospital Los Angeles for FYs 2006-07 and 2007-08 shall be $34,292 and $34,866 respectively.

4. Approve and instruct the Director of Health Services, or his designee, to offer and sign the form Trauma Center Service Augmentation Agreement (TCSAA) Amendment No. 2, substantially similar to Exhibit II, with St. Francis Medical Center (SFMC), effective retroactive to December 1, 2006 through November 30, 2007, for a total maximum amount of approximately $5.7 million, with delegated authority to extend the Agreement for one year at the written request of SFMC unless the County objects for good cause, upon substantially similar terms and conditions and reviewed and approved by County Counsel and the Chief Administrative Office.

5. Approve an appropriation adjustment (Attachment C) to reallocate $9.2 million in "Measure B" Trauma Property Assessment (TPA) funds from Services and Supplies (S&S) ($6.6 million) and Appropriation for Contingencies ($2.6 million) to Other Charges (OC) in the FY 2006-07 "Measure B" TPA Final Budget.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS

The purpose of the recommended actions is to: 1) obtain the Board's approval of contracts necessary to administer the Los Angeles County Trauma Center System for FYs 2006-07 and 2007-08, with payment rates retroactive to July 1, 2006; 2) approve reimbursement rates under the TCSA; 3) establish the annual Trauma Center/Base Hospital fee; 4) approve TCSAA Amendment No. 2 with SFMC and 5) approve an appropriation adjustment to reallocate funding from S&S and Appropriation for Contingencies to OC in the FY 2006-07 Final Budget.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

These actions support the County's Strategic Plan Goal No. 1 for Service Excellence by enhancing the quality and productivity of emergency and trauma services countywide.

FISCAL IMPACT/FINANCING

Trauma Center Service Agreements

For FYs 2006-07 and 2007-08, the total maximum obligation to non-County trauma centers is $31.2 million per fiscal year, pursuant to the rates set forth in Exhibit B of the TCSA. The trauma agreements are comprised of two types of reimbursement: a lump sum portion and payments made based on claims submitted for care provided to eligible trauma patients.
Lump sum portion: A maximum amount of $18.0 million of those funds shall be used annually as an IGT for payment to the State to draw-down Medi-Cal matching funds [Federal Financial Participation (FFP)] and provide the non-County trauma centers, excluding UCLA Medical Center, with an additional $18.0 million annual reimbursement for trauma care (as a public hospital, UCLA Medical Center participates in a program that negates the federal benefit of using an IGT in this regard). The increased level of matching funds (originally $6.0 million in FY 2003-04) was made possible by redirecting unmatched claims-based funding in the prior agreements to the Medi-Cal match which resulted in more overall funding to the non-County trauma centers.

Claims-based payment rates: The current claim-based payment rates reflect a 34% increase as compared to the rates set forth in the previous agreements. This increase is strictly cash-flow related since the maximum County obligation is capped at $12.1 million, which represents an actual decrease of $2.8 million (18.8%)

from the previous maximum obligation of $14.9 million for claims-based payments. The maximum annual County obligation under these agreements is $31.2 million, as compared to an annual maximum obligation of $23.9 million under the previous agreements, an increase of $7.3 million. However, these new agreements reflect funding ($6.0 million) previously approved by the Board for the California Hospital Medical Center and SFMC to cover additional patients due to the closure of the Martin Luther King, Jr./Drew (MLK) trauma center.

St. Francis Trauma Care Augmentation Agreement
In FYs 2006-07 (December 2006 to June 2007) and 2007-08 (July 2007 to November 2007), the total maximum obligation to SFMC is $3.3 million and $2.4 million, respectively, pursuant to the rate set forth in TCSAA Amendment No. 2. (Total fiscal impact for the TCSA and TCSAA Amendment No. 2 is $34.5 million for FY 2006-07 and $33.6 million for FY 2007-08.)

There are sufficient appropriations in the FY 2006-07 "Measure B" TPA Final Budget to cover the expenditures required by the execution of the TCSAs and the TCSAA. However, an appropriation adjustment is needed to reallocate $9.2 million in "Measure B" TPA funds from S&S and Appropriation for Contingencies to OC. For the FY 2007-08 budget process, the Department of Health Services (DHS) will work with the Chief Administrative Office to reallocate funding within the "Measure B" TPA Budget to fulfill the obligations of the TCSAs and the TCSAA.

The new TCSAs provide for an annual trauma center service fee in the amount of $45,470 for FY 2006-07, and $46,230 for FY 2007-08, payable to the County by each non-County and County-operated trauma center, excluding Childrens Hospital Los Angeles for whom the fee shall be $34,292 for FY 2006-07, and $34,866 for FY 2007-08, to offset County costs associated with data collection, monitoring, and evaluation. Estimated annual revenue to the County from these fees is $579,932 and $589,626, respectively, for FYs 2006-07 and 2007-08.

For the TCSAs and the TCSAA, all financing is provided (1) by funding available under State law through the Proposition 99/California Healthcare for Indigents Program (CHIP) and the Maddy Emergency Medical Services Fund (SB 612) totaling approximately $3.7 million annually and (2) Measure B revenue. For FYs 2006-07 and 2007-08, the remaining combined maximum obligation of the TCSAs and TCSAA Amendment No. 2 totaling approximately $30.8 million ($34.5 million minus $3.7 million) and $29.9 million ($33.6 million minus $3.7 million), respectively, will be funded by an allocation of revenue generated by the special tax under Measure B. Measure B funding may vary based on a percentage change, if any, in the total Measure B revenue for FY 2007-08 as compared to FY 2006-07 and an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics, if set by the Board. As a result, the total maximum allocation for FY 2007-08 may exceed the aggregate of $33.6 million after taking into account any Measure B Adjustment.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Trauma Center Service Agreements

On June 24, 2003, the Board approved a two year agreement for FYs 2003-04 and 2004-05. Through subsequent amendments, and most recently on July 11, 2006, the Board approved amendments extending

the agreement, addressing funding, and designating California Hospital Medical Center as a Level II trauma center. Amendment No. 6 is slated to expire on January 31, 2007. This month-to-month extension, not to exceed seven months, which included no payment provisions, was approved by your Board to ensure the continued provision of trauma center services until DHS could negotiate and finalize these new TCSAs. At the time of this extension your Board deferred payment provisions during continued negotiations of the contract. Negotiations for these contracts began nearly two years ago, but required complex financial analysis and negotiations with eleven private trauma centers, which were only completed on January 10, 2007.

The two County-operated trauma centers also operate under the same programmatic terms of the standard agreement as a Memorandum of Understanding (MOU) as required by State trauma regulations. The two County-operated trauma centers will sign MOUs, similar to Exhibit I, effective retroactive to July 1, 2006 through June 30, 2008.

As a result of negotiations, the provisions requiring a contractor to consider former County employees for openings as set forth by Board policy has been modified so that the contractor consider former County employees subject to the Contractor's policies and procedures for laid off employees, amongst other things. In addition, the calculation of damages that the County may collect as a result of a breach by the Contractor is limited to a time period of twelve months, or the remaining period of the TCSA upon breach, whichever is less.

St. Francis Trauma Care Augmentation Agreement

On February 22, 2005, the Board approved the TCSAA with SFMC for one year, with a one-year optional extension which was exercised effective March 1, 2006. SFMC continues to receive a high volume of critical trauma patients redirected from the Martin Luther King Hospital service area, as well as non-trauma patients seeking care at SFMC, the next closest emergency room. Therefore, to ensure that SFMC has adequate capacity and the capability to handle additional trauma and emergency room patients, an extension of the TCSAA is necessary at the rate contained in Exhibit II.

Under the TCSAA Amendment No. 2 with SFMC, the County will continue to provide funding under the Transitional Capacity Allowance provisions for eligible indigent patients at the rate contained in Exhibit II. All provisions for the continuation of trauma services are now contained in the new TCSAs. This contract is for eligible indigent patients who either arrive at SFMC via paramedic ambulance or directly admitted from the SFMC emergency room.

The changes in the agreement were made to be consistent with the MetroCare contract which was established December 1, 2006. The MetroCare contract covers patients treated at the King/Drew Medical Center (KDMC) emergency room who require hospitalization and are referred by KDMC to SFMC.

Upon expiration of this Amendment on November 30, 2007, the parties may agree on a one year extension if, among other things, it is determined that the contractor has treated a higher volume of indigent patients as compared to the prior year, taking into account the general Countywide increase in indigent patients.

The provisions of the TCSAs are provided in Exhibit I, and attached Exhibits A through F; and the provisions of the TCSAA Amendment No. 2 are provided in Exhibit II.

Attachments A and B provide additional information. Attachment C is the appropriation adjustment.

County Counsel has approved the TCSA (Exhibit I) and TCSAA Amendment No. 2 (Exhibit II) as to use and form.

CONTRACTING PROCESS

Non-County hospitals executing the TCSAs are current participants in the County's trauma system and satisfy the State and County criteria and conditions for such participation. It is not appropriate to advertise these agreements on the Office of Small Business' Countywide Web Site.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of these agreements and appropriation adjustment will maintain the current level of trauma services until June 30, 2008, and the augmented transitional capacity allowance until November 30, 2007.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

BAC:cm
TRAUME BD LTR 01 17 07.doc

Attachments (3)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Auditor-Controller
Chair, Emergency Medical Services Commission
Health Care Association of Southern California

SUMMARY OF AGREEMENT

PART 1: TRAUMA CENTER SERVICE AGREEMENT

1. Type of Service:

   Trauma services at 11 non-County trauma centers in Los Angeles County.

2. Address and Contact Person:

   Department of Health Services – Emergency Medical Services (EMS) Agency
   5555 Ferguson Drive, Suite 220
   Los Angeles, California 90022
   Attention: Carol Meyer, Director
   Telephone: (323) 890-7545 Fax: (323) 890-8536
   Email: cmeyer@ladhs.org

3. Term:

   Effective retroactive to July 1, 2006 through June 30, 2008.

4. Financial Information:

   The maximum obligation for the Trauma Center Service Agreements effective retroactive to July 1, 2006 will be $31.2 million for Fiscal Year (FY) 2006-07, and $31.2 million for FY 2007-08. This is funded by Measure B Trauma Property Assessment funds, Proposition 99/California Healthcare for Indigents Program (CHIP), and the Maddy Emergency Medical Services Fund (SB 612). The appropriation adjustment to reallocate a total amount of $9.2 million from Services & Supplies ($6.6 million), and Appropriation for Contingencies ($2.6 million) to Other Charges in the FY 2006-07 Department of Health Services Adopted Budget, will enable the Department of Health Services to transfer the funding to the State so that federal matching dollars can be obtained, and payment will be made directly to the non-County trauma center hospitals, excluding UCLA Medical Center, by the State. As a public hospital, UCLA Medical Center participates in a program that negates the federal benefit of using an intergovernmental transfer in this regard.

   The estimated annual revenue to the County from the Trauma Center/Base Hospital fees payable by each trauma center hospital is $579,932 for FY 2006-07, and $589,626 for FY 2007-08.

5. Primary Geographic Area to be Served:

   Countywide.

6. Accountable for Program Monitoring:

   The County's local EMS Agency, i.e., the Department's EMS Division

7. Approvals:

Emergency Medical Services Agency:	Carol Meyer, Director
Contracts and Grants Division:	Cara O'Neill, Chief
County Counsel:	Edward A. Morrissey, Deputy County Counsel
CAO Budget Unit:	Latisha Thompson

SUMMARY OF AGREEMENT

PART 2: TRAUMA CENTER SERVICE AUGMENTATION AGREEMENT AMENDMENT NO.2

1. Type of Service:

   Trauma services at St. Francis Medical Center

2. Address and Contact Person:

   Department of Health Services – Emergency Medical Services (EMS) Agency
   5555 Ferguson Drive, Suite 220
   Los Angeles, California 90022
   Attention: Carol Meyer, Director
   Telephone: (323) 890-7545 Fax: (323) 890-8536
   Email: cmeyer@ladhs.org

3. Term:

   Effective retroactive to December 1, 2006 through November 30, 2007, with an option to extend an additional 12 months through November 30, 2008.

4. Financial Information:

   The maximum obligation for the Trauma Center Service Augmentation Agreement Amendment No. 2 will be $3.3 million for December 1, 2006 through June 30, 2007, and $2.4 million for FY 2007-08. This is funded by Measure B Trauma Property Assessment funds, Proposition 99/California Healthcare for Indigents Program (CHIP), and the Maddy Emergency Medical Services Fund (SB 612).

5. Primary Geographic Area to be Served:

   Countywide.

6. Accountable for Program Monitoring:

   The County's local EMS Agency, i.e., the Department's EMS Division

7. Approvals:

Emergency Medical Services Agency:	Carol Meyer, Director
Contracts and Grants Division:	Cara O'Neill, Chief
County Counsel:	Edward A. Morrissey, Deputy County Counsel
CAO Budget Unit:	Latisha Thompson

ATTACHMENT B

DESIGNATED TRAUMA CENTERS

NON-COUNTY TRAUMA CENTERS	LEVEL	BASE HOSPITAL	PEDIATRIC TRAUMA CENTER
1. California Hospital Medical Center	II	X	
2. Cedars-Sinai Medical Center	I	X	X
3. Childrens Hospital Los Angeles			X
4. Henry Mayo Newhall Memorial Hospital	II	X	
5. Huntington Memorial Hospital	II	X	
6. Long Beach Memorial Hospital	II	X	X
7. Northridge Hospital Medical Center	II	X	
8. Providence Holy Cross Medical Center	II	X	
9. St. Francis Medical Center	II	X	
10. St. Mary Medical Center	II	X	
11. UCLA Medical Center	I	X	X

COUNTY OPERATED TRAUMA CENTERS

1. Harbor/UCLA Medical Center	I	X	X
2. LAC+USC Medical Center	I	X	X

ATTACHMENT C

BOARD OF SUPERVISORS
OFFICIAL COPY

76R 352M 11/83

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT DEPT'S. No. _____

DEPARTMENT OF Health Services DATE 01/12/2007

AUDITOR CONTROLLER.
THE FOLLOWING APPRPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

Budget Adjustment
Fiscal Year 2006-07
4 Vote

SOURCES:		USES:	
Measure B - Private Facilities Services and Supplies BW9-HS-41016-2000	$6,600,000	Measure B - Administrative / Other Other Charges BW9-HS-41017-5500	$9,200,000
Measure B - Special Tax Fund Appropriation for Contingency BW9-HS-3303	2,600,000		
Total:	$9,200,000	Total:	$9,200,000

JUSTIFICATION:

The appropriation adjustment in the amount of $9,200,000 is necessary to shift Fiscal Year 2006-07 DHS Final Budget Measure B - Trauma Property Assessment funds from Services & Supplies and Appropriation for Contingency to Other Charges to enable these funds to be used as an intergovernmental transfer for payment to the State to draw-down Medi-Cal matching funds.

EM:gt
1/12/07

Efrain Muñoz, Chief
DHS-Controller's Division

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR: ☐ ACTION ☑ RECOMMENDATION

BY: Barbara Hershaw

AUDITOR-CONTROLLER No. 106

01-12-07

APPROVED AS REQUESTED ☒ AS REVISED ☐

for Carolyn Jansen 1/12/07
CHIEF ADMINISTRATIVE OFFICER

APPROVED (AS REVISED):
BOARD OF SUPERVISORS

BY: _____
DEPUTY COUNTY CLERK

SEND 6 COPIES TO THE AUDITOR-CONTROLLER

EXHIBIT I

TRAUMA CENTER SERVICE AGREEMENT
BY AND BETWEEN
COUNTY OF LOS ANGELES
AND
(CONTRACTOR)

FISCAL YEAR 2006-07
AND
FISCAL YEAR 2007-08

01/30/2007

TRAUMA CENTER SERVICE AGREEMENT

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT
TABLE OF CONTENTS

EXHIBIT C PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM

EXHIBIT D TRAUMA CENTER DATA COLLECTION SYSTEM

ATTACHMENT D-1 TEMIS Hospital Hardware & Software Specifications

ATTACHMENT D-2 Trauma Patient Summary (TPS) Form Pages 1 & 2

ATTACHMENT D-3 Hospital Employee Acknowledgment & Confidentiality Agreement

EXHIBIT E DATA ADVISORY COMMITTEE MEMBERSHIP

EXHIBIT F PARAMEDIC BASE HOSPITAL REQUIREMENTS

ATTACHMENT F-1 Communications Management Committee

ATTACHMENT F-2 Base Hospital Form Pages 1 & 2

ATTACHMENT F-3 Receiving Hospital Outcome Data

ATTACHMENT F-4 TEMIS Hospital Hardware & Software Specifications

ATTACHMENT F-5 Hospital Employee Acknowledgment & Confidentiality Agreement

ATTACHMENT F-6 Base Hospital Communication Equipment

ATTACHMENT F-7 Communication Equipment Maintenance Standards

Contract # _____

TRAUMA CENTER
SERVICE AGREEMENT

THIS AGREEMENT is made and entered into this_____ day of _____, 2006,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and _____ (hereafter "Contractor").

WHEREAS , various general acute care hospitals located within Los Angeles County have been identified by County as hospitals which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major trauma; and

WHEREAS , Contractor is willing to accept and care for trauma patients at hospital under County's advanced trauma system and in accordance with the terms and conditions which follow herein; and

WHEREAS , Contractor, by virtue of the parties' execution of this Agreement, is a County designated Trauma Center; and

WHEREAS , this Agreement establishes funding available to Contractor for certain services performed during the term of this Agreement for services to be performed by Contractor described

herein in accordance with the terms and conditions under this Agreement; and

WHEREAS , Contractor has agreed to use its best efforts to maintain continuous participation as a County-designated Trauma Center and Paramedic Base Hospital during the term of this Agreement; and

WHEREAS , the Agreement is authorized by Health and Safety Code sections 1797.204, 1797.252, and 1798.170, Government Code section 26227, as well as by provisions of WIC Section 16946.

NOW , THEREFORE , the parties agree as follows:

1. TERM:

   A. This Agreement supersedes all other previous agreements entitled "Trauma Center Service Agreement" and shall commence effective July 1, 2006, and it shall remain in full force and effect until June 30, 2008, without further action of the parties. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder.

   B. Notwithstanding any other provision of this Agreement, Director of County's Department of Health Services or his duly authorized designee (jointly hereafter referred to as "Director") may immediately suspend

this Agreement at any time if Contractor's license to operate basic or comprehensive emergency services is revoked or suspended. If such licensure, suspension, or revocation remains in effect for a period of at least sixty (60) days, Director may terminate this Agreement upon giving at least thirty (30) days prior written notice to Contractor.

C. Notwithstanding any other provision hereof, Director may suspend this Agreement immediately upon giving written notice to Contractor, if Contractor, its agents, subcontractors, or employees at Contractor may be engaging in a continuing course of conduct which poses an imminent danger to the life or health of patients receiving or requesting medical care and services at Contractor. Any such action by Director shall be subject to the "due process" procedures established in Paragraph 16 hereinbelow.

D. Not withstanding any other provision of this Agreement, in the event the County makes a final decision to implement a central hospital base station concept, Director may withdraw the requirement that Contractor to maintain designation as a base hospital, furnish base hospital services, and meet all requirements set

forth in Exhibit "F", Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference by giving Contractor at least one-hundred eighty (180) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

E. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement with or without cause by giving the other party at least sixty (60) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

F. If the State EMS Authority and the State EMS Commission disapprove for any reason the County's trauma system plan, County may terminate this Agreement by providing written notice to Contractor of the State's action, and by setting forth in the notice an effective date of termination which is no less than thirty (30) days from the date of the County's receipt of notification of the State's action, but which is no more than sixty (60) days from said date.

G. In accordance with this Agreement, Contractor may, during the term of this Agreement, submit claims for services provided to eligible indigent patients. In consideration for services to be performed by Contractor under this Agreement, these claims will be reimbursed at the all-inclusive rates set forth in Exhibit B.

2. ADDITIONAL PROVISIONS: Attached hereto and incorporated herein by reference, is a document labeled "ADDITIONAL PROVISIONS". The terms and conditions therein contained are part of this Agreement.

3. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY):

A. The Department of Health Services ("Department") shall develop and monitor compliance with triage protocols and procedures for County's trauma system.

B. The Department shall be responsible for the development and ongoing evaluation and Performance Improvement of the trauma system.

C. The Department shall be responsible for periodic performance evaluations of the trauma system, which shall be conducted at least every three (3)years in

conjunction with the American College of Surgeons review. The evaluation shall be based, in part, on requirements described in Exhibit "A.I", Level I Trauma Center Requirements, Exhibit "A.II", Level II Trauma Center Requirements, Exhibit "A.III", Level I Pediatric Trauma Center Requirements, and Exhibit "A.IV", Level II Pediatric Trauma Center Requirements, attached hereto and incorporated herein by reference. Results of the trauma evaluation shall be made available to individual participants.

D. The Department shall implement policies and procedures for quality improvement in order to monitor the appropriateness and quality of care rendered to trauma patients in Los Angeles County as described under Paragraph 15 hereinbelow.

E. The Department shall be responsible for maintaining a source of reimbursement for eligible indigent patients described in Exhibit "B", Provisions For Reimbursement of Eligible Indigent Patients, attached hereto and incorporated herein by reference.

F. One or more individuals within the Department shall be designated by Director to liaise with all Los Angeles County designated Trauma Centers with respect to

matters affecting County's advanced trauma system.

G. The Department shall be responsible for ensuring that Trauma Centers and other hospitals that treat trauma patients participate in the data and quality improvement process.

H. The Departments shall be responsible for ensuring that patient inclusion in the data collection system is based on Exhibit "C", Patient Inclusion in the Trauma Center Data System, attached hereto and incorporated herein by reference.

I. The Trauma Center data collection system requirements are described and set forth in Exhibit "D", Trauma Center Data Collection System, attached hereto and incorporated herein by reference. The Department shall comply with all Department responsibilities for the Trauma Center data collection system in Exhibit "D".

J. The Department, after consultation with and advice from the Emergency Medical Services Commission ("EMSC"), EMS Data Advisory Committee shall maintain a comprehensive Trauma Center data collection system. The composition of the EMS Data Advisory Committee, is described in Exhibit "E", Data Advisory Committee Membership, attached hereto and incorporated herein by reference.

K. The Department shall monitor the trauma patient catchment area defined for Contractor to ensure that trauma patients are triaged appropriately to Contractor. Contractor acknowledges receipt of a map defining its catchment area as of the date of execution of this Agreement.

L. The Department may modify trauma patient catchment areas from time to time to meet the needs of the advanced trauma system. In the event that a catchment area is to be changed, then sixty (60) days prior to the effective date of the change, the Department shall give written notice to all designated Trauma Centers. All impacted Trauma Centers which are not County operated, including Contractor, shall be afforded the opportunity to provide written statements regarding the proposed change. If Contractor is adversely affected by the change of the catchment areas, Contractor shall be provided with "due process" as specified in Paragraph 16 hereinbelow prior to the change in the catchment areas.

M. In the event that an existing Trauma Center ceases to participate in the advanced trauma system, the Department shall first attempt to reconfigure the

trauma patient catchment areas so as to provide coverage for the area no longer served by such hospital by utilizing existing Trauma Centers. If coverage cannot be provided by the use of existing Trauma Centers, the Director shall give written notice to Contractor and to all concerned designated Trauma Centers of any Department intention to seek a new hospital to provide the coverage. Contractor and all other concerned designated Trauma Centers shall have the opportunity to provide written statements to Director within ten (10) days of receipt of such notification regarding the proposed change. If Contractor believes it would be adversely affected by the addition of a new Trauma Center in such circumstances, Contractor may present its complaint in accordance with the "due process" provisions specified in Paragraph 16 hereinbelow prior to County designation of the new Trauma Center.

N. Interim System Re-Configuration. The Department may, on an interim basis, restructure the trauma system as it deems necessary, in those instances when a Contractor gives notice that it is withdrawing from the system or when a Contractor is suspended or terminated

from the prehospital care system. In the event that an interim restructuring occurs, any affected Contractor shall be given the opportunity to provide written and oral statements regarding the restructuring to the local EMS agency. The affected existing Contractors shall be provided with the "due process" procedures as specified in Paragraph 16 hereinbelow.

O. The Department shall follow the trauma system policy which addresses the coordination with all health care organizations within the trauma system to facilitate the transfer of an organization member in accordance with the criteria set forth in Paragraph 11 hereinbelow.

4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR:

A. Contractor shall furnish Trauma Center services to patients in need thereof who are delivered, or present themselves, to Contractor. In the provision of such services, Contractor shall comply at all times during the term of this Agreement with the staffing criteria and other requirements of applicable Exhibits "A.I" - "A.IV".

B. The Contractor shall comply with the reimbursement process for eligible indigent patients described in

Exhibit "B", attached hereto and incorporated herein by reference.

C. The Contractor shall include only those patients that meet inclusion in the data collection system based on Exhibit "C", attached hereto and incorporated herein by reference.

D. The Contractor shall comply with all Contractor responsibilities for the Trauma Center data collection system in Exhibit "D", attached hereto and incorporated herein by reference.

E. It is understood and agreed that medical care furnished to patients pursuant to this Agreement shall be provided by physicians duly licensed to practice medicine in the State of California, and the agreement by Contractor to arrange for the furnishing of such treatment at hospital is not to be construed as Contractor entering into the practice of medicine. This provision shall not limit the right of practitioners or nursing personnel affiliated with or employed by Contractor at hospital to render any and all services within the scope of their professional licensure or certification, as permitted by Contractor's rules, regulations, and policies with

respect thereto.

F. Contractor shall maintain designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit "F", Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference. The foregoing base hospital requirement shall not apply to Childrens Hospital Los Angeles or to a Contractor that has lost its designation as a base hospital in accordance with Paragraph 1(D) of this agreement. Furthermore, Contractor is aware that the aforementioned document, Exhibit "F", Paramedic Base Hospital Requirements, is under revision and agrees, upon execution of the revised document, to meet all requirements established therein.

5. INDEMNIFICATION: Contractor shall indemnify, defend, and hold harmless County, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with Contractor's acts and/or omissions arising from and/or relating to this Agreement.

County shall indemnify, defend, and hold harmless Contractor and its officers, employees and agents, from and against any and all liability including but not limited to demands, claims, actions, fees, costs and expenses (including attorney and expert witness fees), arising from or connected with County's acts and/or omissions arising from and/or relating to this Agreement.

6. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and during the term of this Agreement, Contractor shall provide and maintain, and shall require all of its subcontractors to maintain, the following programs of insurance specified in this Agreement. Such insurance shall be primary to and not contributing with any other insurance of self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

   A. Evidence of Insurance: Certificate(s) or other evidence of coverage satisfactory to County shall be delivered to County's Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor-East, Los Angeles, California 90012, prior to commencing services under this Agreement. Such certificates or other evidence shall:

(1) Specifically identify this Agreement.

(2) Clearly evidence all coverages required in this Agreement.

(3) Contain the express condition that Contractor will use best efforts to give County written notice by mail at least thirty (30) calendar days in advance of cancellation for all policies evidenced on the certificate of insurance. Should Contractor receive notice from insurer of a cancellation to take effect earlier than thirty (30) calendar days from such notice, Contractor shall use best efforts to notify County in writing of such cancellation on the next business day.

(4) Include copies of the additional insured endorsement to the commercial general liability policy, adding County of Los Angeles, its Special Districts, its officials, officers, and employees as insurers for all activities arising from this Agreement.

(5) Identify any deductibles or self-insured retentions for County's approval. Contractor shall be responsible for all deductibles as they apply to any insurance coverage with respect to

this agreement.

B. Insurer Financial Ratings: Insurance is to be provided by an insurance company acceptable to County with an A.M. Best rating of not less than A:VII, unless otherwise approved by County.

C. Failure to Maintain Coverage: Failure by Contractor to maintain the required insurance, or to provide evidence of insurance coverage acceptable to County, shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement. County, at its sole option, may obtain damages from Contractor resulting from said breach.

D. Notification of Incidents, Claims, or Suits: Contractor shall report to County:

(1) Any third party claim or lawsuit filed against Contractor arising from or related to services performed by Contractor under this Agreement.

(2) Any loss, disappearance, destruction, misuse, or theft of any kind whatsoever of County property, monies or securities entrusted to Contractor under the terms of this Agreement.

(3) Simultaneously, any injury, death or treatment of a patient provided services covered in this

Agreement for which Contractor provides any report/notice to the Joint Commission on Accreditation of Hospital Organization (JCAHO), or any report/notice as required under Title 22, C.C.R.70737 (e.g., unusual occurrence). Such report to County shall only include the patient name, date, and treatment.

E. Insurance Coverage Requirements for Subcontractors: Except as set forth below, Contractor shall ensure that any and all non-physician subcontractors (e.g. pump technicians) performing medical care and treatment services under this Agreement shall meet the professional liability insurance requirements of this Agreement by either:

(1) Contractor providing evidence of insurance covering the activities of subcontractors, or

(2) Contractor providing evidence submitted by subcontractors evidencing that subcontractors maintain the required insurance coverage. County retains the right to obtain copies of evidence of subcontractor insurance coverage at any time.

The amount of professional liability insurance required in this Agreement for non-physician

subcontractors would be an amount equal to that which the County routinely requires in its agreements with non-physician contractors providing similar medical care and treatment services to the County.

F. Insurance Coverage Requirements for Affiliate Physicians: Contractor shall ensure that any and all physicians, either individually, or by or through a related medical group, physician group, or independent physician association where appropriate, with privileges to perform or otherwise performing any services covered under this Agreement on premises of or used by Contractor maintain professional liability insurance covering liability arising from any error, omission, negligent, or wrongful act of such physician(s) with limits of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement, only if such coverage is consistent with the industry standard in California.

7. SPECIFIC INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance: (written on ISO policy

form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate:	$2 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

B. Automobile Liability Insurance: (written on ISO policy form CA 00 01 or its equivalent) with a limit of liability of not less than One Million Dollars ($1,000,000) for each accident. Such insurance shall include coverage for all "owned", "hired", and "non-owned" vehicles, or coverage for "any auto".

C. Workers Compensation and Employer's Liability: Insurance providing workers compensation benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. If Contractor's employees will be engaged in maritime employment, coverage shall provide workers compensation benefits as required by the U.S. Longshore and Harbor Worker's Compensation Act, Jones Act, or any other Federal law for which Contractor is responsible.

In all cases, the above insurance also shall include Employers' Liability coverage with limits of not less than the following:

Each Accident:	$1 Million
Disease - Policy Limit:	$1 Million
Disease - Each Employee	$1 Million

D. Professional Liability: Insurance maintained by Contractor covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers, or employees with limits of not less than Three Million Dollars ($3,000,000) per occurrence. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement.

8. WAIVERS: Director may waive trauma center criteria contained in Exhibits "A.I" - "A.IV", when it is determined that the conditions necessitating the waiver request will be in effect less than seventy-two (72) hours for any one occurrence and that procedures exist to ensure that patient care is not jeopardized. Waivers may, upon discretion of Director, include but not be limited to the following instances:

A. Temporary inability of Contractor to meet staffing requirements with regard to trauma team or any in-house or on-call or second call physicians whose absence, as determined by Director, would not jeopardize the

welfare of trauma patients.

B. Temporary loss of function or restricted capacity of any of the special facilities, resources or capabilities of Contractor, if such loss or restriction would not jeopardize the welfare of trauma patients. County recognizes that routine servicing and subsequent temporary inoperability ("down time") of the Computerized Tomography (CT) scanner does not require invocation of a waiver.

Contractor shall direct its waiver request to Director's office. If a waiver is given, Contractor shall recontact Director as soon as the temporary staffing or the equipment deficiency for which the waiver was given has been resolved. If a deficiency has not been corrected within the time deemed appropriate by Director, Director may temporarily suspend Contractor's designation as a Trauma Center. In this event, Contractor shall notify surrounding base hospitals and Trauma Centers, and paramedic provider agencies serving Contractor's area that it is on temporary bypass status. When the deficiency necessitating bypass status has been corrected, Director may lift the suspension, and Contractor shall

immediately notify such surrounding hospitals.

9. STANDARDS OF CARE:

A. Contractor shall provide for supervision and monitoring of care rendered under the terms of this Agreement in accordance with the recognized standards thereof through regular review of patient medical records by Contractor's appropriately designated medical staff committee(s) at hospital. In addition, Contractor shall provide for specific quality improvement activities as described in the QUALITY IMPROVEMENT Paragraph 15, hereinbelow.

B. Contractor shall:

(1) maintain Contractor's accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be in conformance at hospital with the standards of the JCAHO which apply to the provision of emergency medical services.

(2) not subject trauma patients to avoidable delay in receiving necessary medical care at Contractor pending financial arrangements.

10. NUMBER OF PATIENTS TO BE TREATED: While the parties contemplate that persons suffering major trauma at locations

near Contractor will normally be delivered to Contractor for care, the parties recognize that County can make no guarantee in this regard and further that County is unable to assure that any minimum number of trauma patients will be delivered to Contractor during the term of this Agreement.

11. PATIENT TRANSFERS:

A. Patients to whom service is being provided hereunder may be transferred between and from trauma centers to other medical facilities, including County-operated facilities, in compliance with JCAHO standards, Title 22 of the California Administrative Code, Emergency Medical Treatment and Active Labor Act (EMTALA), and other laws and protocols governing such transfers, providing that:

(1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and

(2) in accordance with local EMS agency interfacility transfer policies; and

(3) the transfer may not be refused if the receiving facility has the capacity to accept.

B. Contractor agrees to continue to provide services hereunder until a patient is transferred.

C. Contractor shall have written transfer agreements with

trauma centers. Contractor shall develop written criteria for consultation and transfer of patients needing a higher level of care.

D. To the extent that it is not contrary to, or inconsistent with, any Federal or State law, regulation or policy, the County shall take the necessary steps to insure that preference is given to Contractor seeking to effectuate a medically prudent transfer of a patient to a County owned facility.

E. Contractor or other responsible party shall be financially liable for transportation of patients for whom services are rendered hereunder and who are being transferred from Contractor to any other facility. Nothing herein shall prevent Contractor from billing the patient or other financially responsible party for such services.

12. TRAUMA CENTER SIGNS: Contractor may, at its own expense, identify itself as a Trauma Center by placing signs to that effect on Contractor's grounds. Such signs shall exclude any reference to the level of its County designation and shall otherwise conform to local government regulations.

13. TRAUMA TEAM: Contractor agrees to designate trauma teams, whose members must include the general surgeon, and other

team members as appropriate to respond to all trauma codes called either from the field or from the hospital. Upon activation of the trauma code, appropriate team members shall be available as defined in regulations and shall assemble in the trauma resuscitation area.

14. TRAUMA CENTER FEES: By payment as set forth in this paragraph, Contractor agrees to offset a portion of the cost of the data collection effort excluding new hardware, the data management system, and a portion of the County's administrative costs for the trauma system and base hospital operation. The annual Trauma Center/Base Hospital fee for Fiscal Years 2006-07 and 2007-08 shall be Forty-Five Thousand Four Hundred and Seventy Dollars ($45,470) and Forty-Six Thousand Two Hundred and Thirty Dollars ($46,230), respectively, for each Contractor and is due on or before August 31 of the fiscal year. Since the base hospital requirement does not apply to Childrens Hospital Los Angeles, as noted in Paragraph 4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR, Section F., the annual Trauma Center fee for Childrens Hospital Los Angeles for Fiscal Years 2006-07 and 2007-08 shall be Thirty-Four Thousand Two Hundred and Ninety-Two Dollars ($34,292) and Thirty-Four Thousand Eight Hundred and Sixty-Six Dollars ($34,866), respectively, and

is due on or before August 31 of the fiscal year.

If this Agreement is revoked, cancelled, or otherwise terminated on a date other than June 30, the amount reflected herein above for such term shall be prorated, and a reduced amount, based upon the actual number of days of such term that the Agreement is in effect, shall be due County hereunder. If the greater sum has already been paid by Contractor, County shall refund the difference between that payment and the prorated amount.

If this Agreement is revoked, cancelled, or terminated because of Contractor's failure to maintain the trauma system criteria as described in applicable Exhibits "A.I" - "A.IV", or failure to maintain an acceptable level of trauma care as determined by community standards, Contractor shall not be eligible for any such refund.

In any event, County shall refund to Contractor its prorated share of remaining funds contributed by designated County Trauma Centers to the data collection system, if the total cost of such programs, as determined by the County's Auditor Controller and Director in accordance with standard auditing and accounting practices, is found to be less than the total amount contributed by designated Trauma Centers.

15. QUALITY IMPROVEMENT:

A. Specific rights of the Department:

(1) Director may from time to time review Contractor's policies and procedures regarding quality improvement as they pertain to care rendered under this Agreement.

(2) Director may request Contractor to verify that internal follow up is occurring by Contractor on a particular case under review by the Department. Contractor shall respond in writing within fifteen (15) days of Director's written request.

B. Specific responsibilities of Contractor:

(1) Contractor shall conduct a detailed audit of:

(a) all trauma related deaths;

(b) all trauma patient transfers;

(c) all major complications.

(2) Contractor shall abide by the following requirements concerning case audit:

(a) Audit attendances must be documented by signature and rosters retained by Contractor;

(b) Audit minutes must be recorded and retained by Contractor.

(3) All such records shall be available to designees duly authorized by Director during the term of

this Agreement and for a period of seven (7) years thereafter upon request of Director.

(4) Contractor shall further advise Director, upon request, what corrective action was taken on specific cases.

16. DUE PROCESS:

A. Notice of Proposed Adverse Action: In all cases in which the Director has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as hereafter set forth in Subparagraph 16.B., Contractor shall promptly be given written notice of the specific charges and factual basis upon which the Director's action is based. With the exception of summary suspensions or summary suspension with intent to terminate, Contractor shall be afforded a right to request a hearing before implementation of any of the actions which constitute grounds for a hearing. Contractor shall have thirty (30) days following the receipt of such notice within which to file with Director a request for hearing before the EMSC.

B. Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing: summary

suspension of Contractor as a Trauma Center; summary suspension with intent to terminate Agreement; Trauma Center operational and programmatic changes wherein Contractor has been given specific rights herein to request a hearing; modifications to Contractor's trauma patient catchment area; and the proposed addition of a new hospital as a Trauma Center when Contractor believes it would be adversely affected by such addition. Nothing in this paragraph 16 shall affect County's right to terminate Agreement under subparagraph 1.D.

C. Summary Suspension or Summary Suspension with Intent To Terminate: In the case of summary suspensions or summary suspension with intent to terminate this Agreement, Contractor, at its election, shall have the right to request in writing that Director reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) days after the receipt of the reconsideration request. Contractor representatives shall be given an opportunity to meet with Director to discuss the alleged basis for the summary action.

Within ten (10) days following the meeting with

Director, or within ten (10) days following the summary suspension action, Director shall issue a written decision to Contractor regarding the summary suspension. This decision may be that the suspension be continued for a particular time or upon particular condition, that the summary suspension be terminated, that Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem warranted. If Director takes any action other than full and immediate termination of the summary suspension, Contractor may request a hearing on the summary suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Such request shall be delivered to Director within five (5) days of Director's delivery to Contractor of his/her written decision.

D. Time and Place of Hearing: Director shall, within fifteen (15) days of receipt of a request for hearing, file a request for the hearing with the EMSC. The EMSC shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) days, nor more than

ninety (90) days from the filing of the request for a hearing, subject to the convenience and approval of the EMSC; however, if the request is received from Contractor when Contractor is under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible.

E. Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party, within ten (10) days of such request, shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

F. Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

G. Memorandum of Points and Authorities: Subject to the rules of the EMSC, each party shall have the right to submit a memorandum of points and authorities to the EMSC.

H. Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

(1) oral testimony of the parties' representatives;

(2) documentary evidence introduced at the hearing;

(3) briefs or memorandum of points and authorities presented in connection with the hearing;

(4) policies and procedures of the Department;

(5) all officially noticed matters.

I. Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, a tape or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Contractor or by Director, the cost of same shall be borne by such party.

J. Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent

permitted and prescribed in County Code Section 3.20.070B.

17. RESPONSIBILITY FOR INDIGENT PATIENTS: Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

18. STATUS OF CONTRACTOR: The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and nonprofessional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefits of County employees. Except as may otherwise expressly be provided hereunder, Contractor shall furnish all personnel, supplies, equipment, space, furniture, insurance, utilities, and telephone necessary for performance of Contractor's responsibilities set forth in this Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payments from the public or from non-County provider agencies for services provided by Contractor hereunder where entitlement thereto is permitted by law or by separate contract.

19. INTERPRETERS: If Contractor is located in an area where communication problems may exist because of a high concentration of non-English-speaking residents, Contractor shall provide interpreters in accordance with the requirements for such services established under Section 70721, Title 22 of the California Administrative Code.

20. CONSUMER COMPLAINTS:

A. Contractor agrees to comply with all responsibilities and related requirements applicable under Section 70707, Title 22 of the California Administrative Code, to ensure that each patient receiving services hereunder at Contractor is made aware of the following information prior to discharge: the name, location, and telephone number of Contractor's representative responsible for handling patient complaints; means, including forms, for submitting complaints in writing to that representative; a "Bill of Rights" defining patient prerogatives relative to matters on care, services, communication, and registry of complaints.

B. Contractor shall, on request, furnish to Director, copies of all trauma patient complaints, and the results of Contractor's investigation and action taken. All of Contractor's administrative files maintained on

such complaints shall be open to inspection by Director. Such inspection rights shall not extend to reports of medical staff committees, nor to incident reports or other attorney-client communication or materials qualifying for the attorney-client privilege.

21. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States mail, certified or registered postage prepaid return receipt requested, to the parties at the following addresses and to the attention of the persons named. County's Director shall have the authority to issue all notices which are required or permitted by County hereunder. Addresses and persons to be notified may be changed by a party by giving at least ten (10) calendar days prior written notice thereof to the other.

A. Notices to County shall be addressed as follows:

(1) Department of Health Services
Emergency Medical Systems Division
5555 Ferguson Drive, Suite 220
Commerce, California 90022
Attention: Director

(2) Department of Health Services
Contracts and Grants Division
313 North Figueroa Street

Sixth Floor - East
Los Angeles, California 90012
Attention: Division Chief

B. Notice to Contractor shall be addressed as follows:

_____
_____
_____
_____
Attention: Chief Executive Officer

IN WITNESS WHEREOF , the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Bruce A. Chernof, M.D.
Director and Chief Medical Officer

_____
Contractor

By _____
Signature

_____
Printed Name

_____
Title

_____
Date

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By _____
Cara O'Neill, Chief
Contracts and Grants Division

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

1. ADMINISTRATION AND MONITORING:

A. Director or his authorized designee shall have the authority to administer this Agreement on behalf of County.

B. Contractor extends to Director the right to review and monitor Contractor's trauma program policies and procedures pertinent to this Agreement and to inspect Contractor's facility and records for contractual compliance with State and local EMS Agency policies and regulations.

Inspection by County staff shall be conducted during County's normal business hours and only after giving Contractors at least three (3) working days prior written notice thereof. In computing the three working days, a Saturday, Sunday, or legal holiday shall not be included. Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting three (3) days. Nothing herein shall preclude County staff authorized by Director from

making unannounced visits to determine compliance with criteria contained in Exhibits "A.I"-"A.IV", attached hereto and incorporated herein by reference.

2. CONTRACT COMPLIANCE: Should Contractor, as initially determined by Director, fail to comply with any provision set forth hereunder as a Contractor responsibility or obligation, Director may do any or all of the following in addition to other rights which Director of County may have hereunder or at law:

   A. Send Contractor a written warning itemizing the area(s) of concern and requesting or specifying a plan for remedial action.

   B. Send Contractor a written itemized listing of the area(s) of concern and permit Contractor to voluntarily request temporary suspension of Contractor for a period of thirty (30) days or less to allow for remedial action to be taken.

   C. Send Contractor a written itemized listing of the area(s) of concern and summarily suspend, or summarily suspend with intent to terminate, Contractor. Any such action by County shall be subject to the "due process"

procedures established in Paragraph 16 of the body of the Agreement.

3. LICENSES: Contractor shall obtain and maintain, during the term of this Agreement, all appropriate licenses, permits, certifications, accreditations, or other authorizations required by law for operation at its facility and for the provision of services hereunder. Contractor, in its operation, shall also comply with all applicable local, state, and Federal statutes, ordinances, and regulations.

4. CONFIDENTIALITY: Contractor agrees to maintain the confidentiality of its records, including billings, in accordance with all applicable State, Federal, and local laws, ordinances, rules, regulations, and directives relating to confidentiality. Contractor shall inform all of its officers, employees, and agents, and others providing services hereunder of said confidentiality provisions. County shall maintain the confidentiality of patient medical records made available hereunder in accordance with the customary standards and practices of governmental third party payers.

5. RECORDS AND AUDITS:

ADDITIONAL PROVISIONS

A. Records of Services Rendered: Contractor shall maintain books and records of services rendered to all patients provided trauma service at Contractor hereunder, including discharge dispositions, in accordance with Contractor's customary record-keeping requirements. All patient records must comply with general acute care hospital licensure requirements and JCAHO standards applicable to books and records of services rendered. Such books and records shall be retained by Contractor for a minimum period of seven (7) years following the discharge of a patient. Patient records for minors shall be retained either for seven (7) years following the discharge of the patient or until the minor's 19th birthday, whichever is later. During such seven (7) year period, all such records, as well as other records and reports maintained by Contractor pertaining to this Agreement, shall be retained by Contractor at a location in Los Angeles County, and shall be available during Contractor's normal business hours to duly authorized representatives of Director upon request for review and

copying.

In the event County staff desire to conduct any review of Contractor's records authorized under this Paragraph, Contractor shall be given written notice at least ten (10) days in advance of any such review. Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting ten (10) days.

Contractor's Director of Utilization Review and its Director of Medical Records shall be permitted to participate in the review and Contractor shall fully cooperate with County's representatives. Contractor shall allow County's representatives access to all medical records and reports, and other records pertaining to this Agreement, and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractors at County's customary rate for record copying services. Such inspection rights shall not extend to the proceedings or records of Contractor's organized committees or its medical staff,

having as their responsibility the evaluation and improvement of the quality of care rendered in the hospital, which are protected by Evidence Code, Section 1157. An exit conference shall be held following the performance of such review activities at which time the results of the review shall be discussed with Contractor representatives prior to the generation of any final written report or action by Director based on such audit or review. The exit conference shall be held on site prior to the departure of the reviewers and Contractor representatives shall be provided with an oral or written list of preliminary findings at the exit conference.

B. Federal Access to Records: If, and to the extent that, Section 1861 (v) (1) (I) of the Social Security Act [42 U.S.C. Section 1395x (v) (1) (I)] is applicable, Contractor agrees that for a period of four years following the furnishing of trauma services to a patient by Contractor, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human

Services or to the Comptroller General of the United States, or to any of their duly authorized representatives, the contract, books, documents, and records of Contractors which are necessary to verify the nature and extent of the cost of such services. Furthermore, if Contractor carries out any of the services provided hereunder through a subcontract with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve-month period with a related organization (as that term is defined under Federal law), Contractor agrees that each such subcontract shall provide for such access to the subcontract, books, documents, and records of the subcontractor.

6. COUNTY'S QUALITY ASSURANCE PLAN: County or its Agents will evaluate Contractor's performance under this Agreement at least every two (2) years. Such evaluation will include assessing Contractor's compliance with all contract terms and performance standards. Contractor deficiencies which County determines are severe or continuing and that may place performance of this Agreement in jeopardy if not corrected will be reported to the Board of Supervisors. The

report will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, County may terminate this Agreement or impose other penalties as specified in this Agreement.

7. CONTRACTOR'S PERFORMANCE DURING CIVIL UNREST OR DISASTER: Contractor recognizes that health care facilities maintained by County provide care essential to the residents of the communities they serve, and that these services are of particular importance at the time of riot, insurrection, civil unrest, natural disaster, or similar event. Notwithstanding any other provision of this Agreement, full performance by Contractor during any riot, insurrection, civil unrest, natural disaster, or similar event is not excused if such performance remains physically possible. Failure to comply with this requirement shall be considered a material breach by Contractor for which Director may suspend or County may immediately terminate this Agreement.

8. INDEPENDENT CONTRACTOR STATUS: This Agreement is by and between the County of Los Angeles and Contractor and it is not intended, and shall not be construed, to create the

relationship of agent, servant, employee, partnership, joint venture, or association, as between County and Contractor.

Contractor understands and agrees that all Contractor employees furnishing services pursuant to this Agreement are, for purposes of Workers' Compensation liability, employees solely of Contractor and not of County.

Contractor shall bear the sole responsibility and liability for furnishing workers' compensation benefits, if applicable, to any person for injuries arising from, or connected with, services performed on behalf of Contractor pursuant to this Agreement.

9. NONDISCRIMINATION IN SERVICES: Contractor shall not discriminate in the provision of services hereunder because of race, color, religion, national origin, ancestry, sex, age, or physical or mental disability, or medical condition, in accordance with applicable requirements of State and Federal law.

10. NONDISCRIMINATION IN EMPLOYMENT: Contractor's employment practices and policies shall also meet all applicable State and Federal nondiscrimination requirements.

11. FAIR LABOR STANDARDS ACT: Contractor shall comply with all

applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its agents, officers, and employees from and against any and all liability including, but not limited to wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law including, but not limited to, the Federal Fair Labor Standards Act for services performed by Contractor's employees for which County may be found jointly or solely liable.

12. EMPLOYMENT ELIGIBILITY VERIFICATION: Contractor warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others, and that all its employees performing services hereunder meet the citizenship or alien status requirements contained in Federal statutes and regulations. Contractor shall retain such documentation for all covered employees for the period prescribed by law. Contractor shall indemnify, defend, and hold harmless, the County, its officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or County in connection with any

alleged violation of Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

13. STAFF PERFORMANCE WHILE UNDER THE INFLUENCE: Contractor shall use reasonable efforts to ensure that no employee or physician will perform services hereunder while under the influence of any alcoholic beverage, medication, narcotic, or other substance that might impair his/her physical or mental performance.

14. CONTRACTOR'S WILLINGNESS TO CONSIDER COUNTY'S EMPLOYEES FOR EMPLOYMENT: Contractor agrees to receive referrals from County's Department of Human Resources of qualified permanent employees who are targeted for layoff or qualified former employees who have been laid off and are on a re-employment list during the life of this Agreement. Such referred permanent or former County employees shall be given consideration of employment as Contractor vacancies occur after the implementation and throughout the term of this Agreement; subject to the following: (i) Contractor's collective bargaining agreement(s); (ii) Contractor's personnel policies and procedures; (iii) Contractor's own

employees targeted for layoffs or who have been laid off; and (iv) the most qualified applicant.

Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person shall acquire any rights as a third party beneficiary of this Agreement.

15. CONSIDERATION OF GREATER AVENUES FOR INDEPENDENCE ("GAIN") PROGRAM OR GENERAL RELIEF OPPORTUNITY FOR WORK ("GROW") PARTICIPANTS FOR EMPLOYMENT: Should Contractor require additional or replacement personnel after the effective date of this Agreement, Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services' Greater Avenues for Independence ("GAIN") or General Relief Opportunity for Work ("GROW") Programs, who meet Contractor's minimum qualification for the open position. For this purpose, consideration shall mean that Contractor will interview qualified candidates. The County will refer GAIN/GROW participants by job category to the Contractor. In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees

shall be given first priority.

16. TERMINATION FOR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Agreement if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment, or extension of the Agreement or the making of any determination with respect to the Contractor's performance pursuant to the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by the Contractor.

Contractor shall immediately report any attempt by a County officer, or employee, or agent to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (213) 974-0914 or (800) 544-6861.

Among other items, such improper consideration may take

the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

17. RESTRICTIONS ON LOBBYING: If any Federal monies are to be used to pay for Contractor's services under this Agreement, Contractor shall comply with all certification and disclosure requirements prescribed by Section 319, Public Law 101-121 (Title 31, United States Code, Section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds provided under this Agreement also fully comply with all such certification and disclosure requirements.

18. COUNTY LOBBYISTS: Contractor and each County lobbyist or County lobbying firm as defined in Los Angeles County Code Section 2.160.010, retained by Contractor, shall fully comply with the County Lobbyist Ordinance, Los Angeles County Code Chapter 2.160. Failure on the part of Contractor or any County lobbyist or County lobbying firm retained by Contractor to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement.

19. UNLAWFUL SOLICITATION: Contractor shall inform all of its employees of the provision of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of the Business and Professions Code of the State of California (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provision by its employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney, it will refer the patient to the attorney referral service of those bar associations within Los Angeles County that have such a service.

20. CONFLICT OF INTEREST: No County officer or employee whose position in County enables him or her to influence the award or County administration of this Agreement or any competing agreement shall participate in the negotiation of this Agreement. No County employee with a spouse or economic dependent employed in any capacity by Contractor herein, shall participate in the negotiation of this Agreement, or have a direct or indirect financial interest in this

Agreement.

No officer, subcontractor, agent, or employee of Contractor who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.

21. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION:

A. Assignment of Delegation to Subcontractor: Contractor shall not assign its rights or delegate its duties under this Agreement by subcontract, or both, whether in whole or in part, without the prior written consent of County where such assignment or delegation materially changes the operation of the trauma center in performing services under this Agreement. Any assignment or delegation which does not have such prior County consent shall be null and void. For purposes of this Paragraph, such County consent shall require a written amendment to this Agreement which is formally approved and executed by the parties. Any billings to County by any delegatee or assignee on any claim under

this Agreement, absent such County consent, shall not be paid by County. Any payments by County to any delegatee or assignee on any claim under this Agreement, in consequences of any such County consent, shall reduce dollar for dollar any claims which Contractor may have against County and shall be subject to set-off, recoupment, or other reduction for any claims which County may have against Contractor, whether under this Agreement or otherwise.

B. Shareholders or partners, or both, of Contractor may sell, exchange, assign, divest, or otherwise transfer any interest they may have therein. However, in the event any such sale, exchange, assignment, divestment, or other transfer is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of this Agreement, then prior written notice thereof by County's Board of Supervisors shall be required. Any payments by County to Contractor on any claim under this Agreement shall not waive or

constitute such County consent. Consent to any such sale, exchange, assignment, divestment, or other transfer shall be refused only if County, in its sole judgement, determines that the transferee(s) is (are) lacking in experience, capability, or financial ability to perform all Agreement services and other work. This in no way limits any County right found elsewhere in this Agreement, including, but not limited to, any right to terminate this Agreement.

22. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: Contractor shall assure that the locations where services are provided under provisions of this Agreement are operated at all times in accordance with County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulation relating to the property. County's periodic monitoring visits to Contractor's facilities shall include a review of compliance with the provisions of this Paragraph.

23. CONFLICT OF TERMS: To the extent that any conflict exists between the language of the body of this Agreement and of

the language of the exhibits attached hereto, the former shall govern and prevail.

24. MERGER PROVISION: The body of this Agreement, together with the exhibits attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Agreement. No addition to, or alteration of the terms of this Agreement, whether by written or verbal understanding of the parties, their officers, agents, or employees, shall be valid and effective unless made in the form of a written amendment to this Agreement which is formally adopted and executed by the parties in the same manner as this Agreement.

25. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Contractor acknowledges that County has established a goal of ensuring that all individuals who benefit financially from County through County contracts are in compliance with their court-ordered child, family, and spousal support obligations in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

As required by County's Child Support Compliance

Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the terms of this Agreement maintain compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 U.S.C. Section 653a) and California Unemployment Insurance Code (Section 1088.55), and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department (CSSD) Notices of Wage and Earnings Assignment for Child, Family, or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246 (b).

26. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in the CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM Paragraph immediately above, shall constitute a default by Contractor under this Agreement. Without limiting the rights and remedies available to County under any other provision of this

Agreement, failure to cure such defaults within ninety (90) calendar days of written notice shall be grounds upon which County may terminate this contract pursuant to the "Termination for Default" Paragraph of this Agreement (or "Term and Termination" Paragraph of this Agreement, whichever is applicable) and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

27. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director within thirty (30) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Contractor or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar

is in whole or in part.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Contractor or its staff members from such participation in a Federally funded health care program.

Failure by Contractor to meet the requirements of this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement.

28. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: Contractor shall notify its employees that they may be eligible for the Federal Earned Income Credit under the Federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

29. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. A responsible contractor is a contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity, and experience to satisfactorily perform the contract. It is County's

policy to conduct business only with responsible contractors.

B. Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if County acquires information concerning the performance of Contractor under this Agreement or other contracts, which indicates that Contractor is not responsible, County may or otherwise in addition to other remedies provided under this Agreement, debar Contractor from bidding on County contacts for a specified period of time not to exceed three (3) years, and terminate this Agreement and any or all existing contracts Contractor may have with County.

C. County may debar Contractor if the Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated any terms of this Agreement or other contract with County or a nonprofit corporation created by the County, (2) committed any act or omission which negatively reflects on Contractor's quality, fitness, or capacity to perform a contract with County or any other public entity, or

engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against County or any other public entity.

D. If there is evidence that Contractor may be subject to debarment, Director will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before County's Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor or Contractor's representative, or both, shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a proposed decision, which shall contain a recommendation regarding whether Contractor should be debarred, and, if so, the appropriate length of time of the debarment. If Contractor fails to avail itself of the opportunity to

submit evidence to the Contractor Hearing Board, Contractor shall be deemed to have waived all rights of appeal.

F. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendations of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

G. These terms shall also apply to any subcontractors of Contractor, vendor, or principal owner of Contractor, as defined in Chapter 2.202 of the County Code.

30. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION: Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible, or excluded or whose principals are suspended, debarred, ineligible, or excluded from securing federally funded contracts. By executing this Agreement, Contractor

certifies that neither it nor any of its owners, officers, partners, directors, or other principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contacts. Further, by executing this Agreement, Contractor certifies that, to its knowledge, none its subcontractors, at any tier, or any owner, officer, partner, director, or other principal of any subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Agreement, should it or any of its subcontractors or any principals of either be suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Agreement upon which the County may immediately terminate or suspend this Agreement.

31. SEVERABILITY: If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of Agreement and the application of such provision to other persons or circumstances shall not

be affected thereby.

32. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996: The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA). Contractor understands and agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.
The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that it is separately and independently

responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

33. COMPLIANCE WITH APPLICABLE LAWS: Contractor shall comply with all applicable Federal, State, and local laws, rules, regulations, ordinances, and directives, and all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference.

Contractor shall indemnify and hold harmless the County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, arising from or related to any violation on the part of the Contractor or its employees, agents, or subcontractors of any such laws, rules, regulations, ordinances, or directives.

34. COMPLIANCE WITH CIVIL RIGHTS LAWS: Contractor hereby assures that it will comply with all applicable provisions of the Civil Rights Act of 1964, 42 U.S.C. Sections 2000 (e) (1) through 2000 (e) (17), to the end that no person shall, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.

35. GOVERNING LAW, JURISDICTION, AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. The Agreement agrees and

consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

36. SUBCONTRACTING:

A. The overall provisions of trauma services may not be subcontracted by the Contractor without the advance approval of the County. Any attempt by Contractor to subcontract without prior consent of the County may be deemed a material breach of this Agreement.

B. If Contractor desires to subcontract, Contractor shall provide the following information promptly at the County's request:

(1) A description of the work to be performed by the subcontractor.

(2) A draft copy of the proposed subcontract; and

(3) Other pertinent information and/or certifications requested by the County.

C. Contractor shall indemnify and hold the County harmless with respect to the activities of each and every

subcontractor in the same manner and to the same degree as if such subcontractor(s) were Contractor employees.

D. Contractor shall remain fully responsible for all performances required of it under this Agreement, including those that Contractor has determined to subcontract, notwithstanding the County's approval of Contractor's proposed subcontract.

E. The County's consent to subcontract shall not waive the County's right to prior and continuing approval of any and all personnel, including subcontractor employees, providing services under this Agreement. Contractor is responsible to notify its subcontractors of this County right.

F. The County's Project Director is authorized to act for and on behalf of the County with respect to approval of any subcontract and subcontractor employees.

G. Contractor shall be solely liable and responsible for all payments or other compensation to all subcontractors and their officers, employees, agents, and successors in interest arising through services performed hereunder, notwithstanding the County's

consent to subcontract.

H. Contractor shall obtain certificates of insurance, which establish that the subcontractor maintains all the programs of insurance required by the County from each approved subcontractor. Contractor shall ensure delivery of all such document to: County of Los Angeles, Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor East, Los Angeles, California 90012, before any subcontractor employee may perform any work hereunder.

37. TERMINATION FOR MATERIAL BREACH AND/OR ANTICIPATORY BREACH:

A. The County may, by written notice to Contractor, terminate the whole or any part of this Agreement, if, in the judgment of County's Project Director.

(1) Contractor has materially breached this Agreement;

(2) Contractor expressly repudiates this Agreement by an unequivocal refusal to perform; or

(3) In the event the County intends to terminate this Agreement in accordance with Paragraph 37, it shall give thirty (30) days written notice to the Contractor that it is in material breach and/or

anticipatory breach of this Agreement. In this notice of intended termination, the Director shall set forth the facts underlying its claim that the Contractor is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the County may authorize in writing) of receipt of said notice shall revive the Agreement in effect for the remaining term.

B. In the event that the County terminates this Agreement in whole or in part as provided in Sub-paragraph 37A above, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. Contractor shall continue the performance of this Agreement to the extent not terminated under the provisions of this sub-paragraph. The parties agree

that this particular damage provision (i.e., that the Contractor shall be liable to the County for all excess costs incurred by the County) shall be limited to a time period of twelve months or the remaining period of this Agreement upon breach, whichever is less.

C. Except with respect to material breach of any subcontractor, Contractor shall not be liable for any such excess costs of the type identified in the subparagraph above if its failure to perform this Agreement arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather, but in every case, the failure to perform must be beyond the control and without the fault or negligence of Contractor. If the failure to perform is caused by the default of a subcontractor, and if such

default arises out of causes beyond the control of both Contractor and subcontractor, and without the fault or negligence of either of them, Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Subparagraph 37C, the terms "subcontractor" and "subcontractors" mean subcontractor(s) at any tier.

D. If, after the County has given notice of material breach and/or anticipatory breach under the provisions of this Sub-paragraph 37C, it is determined by the County that Contractor was not in material breach and/or anticipatory breach under the provisions of this Sub-paragraph 37C, or that the material breach and/or anticipatory breach was excusable under the provisions of Sub-paragraph 37C, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Sub-paragraph 37A.

E. The rights and remedies of the County provided in this Sub-paragraph 37 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

38. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION / TERMINATION OF AGREEMENT: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provisions shall survive the expiration or other termination of this Agreement.

39. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: The Contractor shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los

Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in English as Attachment "1" and in Spanish as Attachment "2" of the Additional Provisions Exhibit of this Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

40. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used.

41. RECYCLED BOND PAPER: Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at County landfills, Contractor agrees to use

recycled-content paper to the maximum extent possible in connection with services to be performed by Contractor under this Agreement.

No shame.
No blame.
No names.

Newborns can be safely given up at any Los Angeles County hospital emergency room or fire station.

In Los Angeles County:
1-877-BABY SAFE
1-877-222-9723
www.babysafela.org

State of California
Gray Davis, Governor

Health and Human Services Agency
Grantland Johnson, Secretary

Department of Social Services
Rita Saenz, Director

Los Angeles County Board of Supervisors
Gloria Molina, Supervisor, First District
Yvonne Brathwaite Burke, Supervisor, Second District
Zev Yaroslavsky, Supervisor, Third District
Don Knabe, Supervisor, Fourth District
Michael D. Antonovich, Supervisor, Fifth District

This initiative is also supported by First 5 LA and INFO LINE of Los Angeles.

What is the Safely Surrendered Baby Law?
California's Safely Surrendered Baby Law allows parents to give up their baby confidentially. As long as the baby has not been abused or neglected, parents may give up their newborn without fear of arrest or prosecution.

How does it work?
A distressed parent who is unable or unwilling to care for a baby can legally, confidentially and safely give up a baby within three days of birth. The baby must be handed to an employee at a Los Angeles County emergency room or fire station. As long as the child shows no signs of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, workers will use bracelets to help connect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent.

What if a parent wants the baby back?
Parents who change their minds can begin the process of reclaiming their newborns within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?
In most cases, a parent will bring in the baby. The law allows other people to bring in the baby if they have legal custody.

Does the parent have to call before bringing in the baby?
No. A parent can bring in a baby anytime, 24 hours a day, 7 days a week so long as the parent gives the baby to someone who works at the hospital or fire station.

Does a parent have to tell anything to the people taking the baby?
No. However, hospital personnel will ask the parent to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the child. Although encouraged, filling out the questionnaire is not required.

What happens to the baby?
The baby will be examined and given medical treatment, if needed. Then the baby will be placed in a pre-adoptive home.

What happens to the parent?
Once the parent(s) has safely turned over the baby, they are free to go.

Why is California doing this?
The purpose of the Safely Surrendered Baby Law is to protect babies from being abandoned by their parents and potentially being hurt or killed. You may have heard tragic stories of babies left in dumpsters or public bathrooms. The parents who committed these acts may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had nowhere to turn for help, they abandoned their infants. Abandoning a baby puts the child in extreme danger. It is also illegal. Too often, it results in the baby's death. Because of the Safely Surrendered Baby Law, this tragedy doesn't ever have to happen in California again.

A baby's story
At 8:30 a.m. on Thursday, July 25, 2002, a healthy newborn baby was brought to St. Bernardine Medical Center in San Bernardino under the provisions of the California Safely Surrendered Baby Law. As the law states, the baby's mother did not have to identify herself. When the baby was brought to the emergency room, he was examined by a pediatrician, who determined that the baby was healthy and doing fine. He was placed with a loving family while the adoption process was started.

Every baby deserves a chance for a healthy life. If someone you know is considering abandoning a newborn, let her know there are other options.

It is best that women seek help to receive proper medical care and counseling while they are pregnant. But at the same time, we want to assure parents who choose not to keep their baby that they will not go to jail if they deliver their babies to safe hands in any Los Angeles County hospital ER or fire station.

Sin pena.
Sin culpa.
Sin peligro.

Los recién nacidos pueden ser entregados en forma segura en la sala de emergencia de cualquier hospital o en un cuartel de bomberos del Condado de Los Angeles.

En el Condado de Los Angeles:
1-877-BABY SAFE
1-877-222-9723
www.babysafela.org

Estado de California
Gray Davis, Gobernador

Agencia de Salud y Servicios Humanos
(Health and Human Services Agency)
Grantland Johnson, Secretario

Departamento de Servicios Sociales
(Department of Social Services)
Rita Saenz, Directora

Consejo de Supervisores del Condado de Los Angeles
Gloria Molina, Supervisora, Primer Distrito
Yvonne Brathwaite Burke, Supervisora, Segundo Distrito
Zev Yaroslavsky, Supervisor, Tercer Distrito
Don Knabe, Supervisor, Cuarto Distrito
Michael D. Antonovich, Supervisor, Quinto Distrito

Esta Iniciativa tambien esta apollada por First 5 LA y INFO LINE de Los Angeles.

¿Qué es la Ley de Entrega de Bebés Sin Peligro?

La Ley de Entrega de Bebés Sin Peligro de California permite a los padres entregar a su recién nacido confidencialmente. Siempre que el bebé no haya sufrido abuso ni negligencia, padres pueden entregar a su recién nacido sin temor a ser arrestados o procesados.

¿Cómo funciona?

El padre/madre con dificultades que no pueda o no quiera cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura, dentro de los tres días del nacimiento. El bebé debe ser entregado a un empleado de una sala de emergencias o de un cuartel de bomberos del Condado de Los Angeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden empezar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Angeles, al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

En la mayoría de los casos, los padres son los que llevan al bebé. La ley permite que otras personas lleven al bebé si tienen la custodia legal del menor.

¿Los padres deben llamar antes de llevar al bebé?

No. El padre/madre puede llevar a su bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, mientras que entregue a su bebé a un empleado del hospital o de un cuartel de bomberos.

¿Es necesario que el padre/madre diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital le pedirá que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para los cuidados que recibirá el bebé. Es recomendado llenar este cuestionario, pero no es obligatorio hacerlo.

¿Qué ocurrirá con el bebé?

El bebé será examinado y, de ser necesario, recibirá tratamiento médico. Luego el bebé se entregará a un hogar preadoptivo.

¿Qué pasará con el padre/madre?

Una vez que los padres hayan entregado a su bebé en forma segura, serán libres de irse.

¿Por qué California hace esto?

La finalidad de la Ley de Entrega de Bebés Sin Peligro es proteger a los bebés del abandono por parte de sus padres y de la posibilidad de que mueran o sufran daños. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Es posible que los padres que cometieron estos actos hayan estado atravesando dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus recién nacidos porque tenían miedo y no tenían adonde recurrir para obtener ayuda. El abandono de un recién nacido lo pone en una situación de peligro extremo. Además es ilegal. Muy a menudo el abandono provoca la muerte del bebé. Ahora, gracias a la Ley de Entrega de Bebés Sin Peligro, esta tragedia ya no debe suceder nunca más en California.

Historia de un bebé

A las 8:30 a.m. del jueves 25 de julio de 2002, se entregó un bebé recién nacido saludable en el St. Bernardine Medical Center en San Bernardino, en virtud de las disposiciones de la Ley de Entrega de Bebés Sin Peligro. Como lo establece la ley, la madre del bebé no se tuvo que identificar. Cuando el bebé llegó a la sala de emergencias, un pediatra lo revisó y determinó que el bebé estaba saludable y no tenía problemas. El bebé fue ubicado con una buena familia, mientras se iniciaban los trámites de adopción.

Cada recién nacido merece una oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele qué otras opciones tiene.

Es mejor que las mujeres busquen ayuda para recibir atención médica y asesoramiento adecuado durante el embarazo. Pero al mismo tiempo, queremos asegurarles a los padres que optan por no quedarse con su bebé que no irán a la cárcel si dejan a sus bebés en buenas manos en cualquier sala de emergencia de un hospital o en un cuartel de bomberos del Condado de Los Angeles.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.I
LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

EXHIBIT A.I
TRAUMA CENTER REQUIREMENTS
LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the Trauma Center;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the Trauma Center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the Trauma Center the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response

was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a Trauma Center if:

   (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;

   (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

   (3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the Trauma Center or a residency program formally affiliated with a Trauma Center where senior residents can participate in educational rotations, which has

been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a Trauma Center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a Trauma Center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to Trauma Center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS:**

1. A licensed hospital which has been designated as a Level I Trauma Center by the EMS Agency.

2. Appropriate pediatric equipment and supplies and the capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.

4. ReddiNet System where geographically available.

5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
   a. recommending trauma team physician privileges;
   b. working with nursing and administration to support the needs of trauma patients;
   c. developing trauma treatment protocols;
   d. determining appropriate equipment and supplies for trauma care;
   e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
   f. having authority and accountability for the quality improvement peer review process;
   g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
   h. coordinating pediatric trauma care with other hospital and professional services;

i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.

6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administrative ability, and responsibilities that include but are not limited to:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured patient;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
   c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.

9. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists:

a. General Surgery
b. Neurologic
c. Obstetric/Gynecologic
d. Ophthalmologic
e. Oral or Maxillofacial or Head/Neck
f. Orthopaedic
g. Plastic
h. Urologic

10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
    a. Anesthesiology
    b. Emergency Medicine
    c. Internal Medicine
    d. Pathology
    e. Psychiatry
    f. Radiology

11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS:**

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:
    a. Immediately Available:
        (1) General Surgery:
            A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

            (Requirement may be fulfilled by a supervised senior resident as defined in Section A-12 of

this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u>:

(1) Cardiothoracic
(2) General Surgeon *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second general surgeon.)*
(3) Hand
(4) Neurologic (Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)
(5) Obstetric/Gynecologic
(6) Ophthalmic
(7) Oral or Maxillofacial or Head/Neck
(8) Orthopedic
(9) Pediatric
(10) Plastic
(11) Reimplantation/Microsurgery *(This surgical service may be provided through a written*

transfer agreement at Level I and Level II Trauma Centers.)

(12) Urologic

(13) Vascular (Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for adult and pediatric trauma

patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:
a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

(2) Anesthesiologist:
Anesthesiology, in-house and immediately available at all times.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of

providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

b. Promptly Available:
   (1) Anesthesiologist (Second physician on call.)
   (2) Emergency Medicine (Second physician on call.)
   (3) Radiologist

The on-call anesthesiologist, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

c. Available for Consultation:
   (1) Cardiologist
   (2) Gastroenterologist
   (3) Hematologist
   (4) Infectious Disease Specialist
   (5) Internist
   (6) Nephrologist
   (7) Neurologist
   (8) Pathologist
   (9) Pediatrician
   (10) Pulmonary Disease Specialist

D. **ADDITIONAL SERVICE CAPABILITIES:**

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

a. designate a Medical Director;
b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
c. designate an emergency physician to be a member of the trauma team;
d. provide emergency medical services to adult and pediatric patients;

e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
g. comply with current Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;
b. cardiopulmonary bypass equipment;
c. operating microscope;
d. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
e. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code.(A Surgical Intensive Care Unit is acceptable.)

3. **Intensive Care Service:**

In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

a. for trauma patients, the ICU's may be separate specialty units;
b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
c. have a qualified specialist in house and immediately available to care for the trauma patients in the intensive care unit. (*The qualified specialist may be a resident with two*

(2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.); and

d. have the qualified specialist in (3) above be a member of the trauma team.

4. **Radiological Service:**

a. The radiological service shall have <u>immediately available</u> a radiological technician capable of performing:
   (1) plain films; and
   (2) computed tomography imaging (CT).

b. A radiological service shall have the following additional services <u>promptly available</u>:
   (1) angiography; and
   (2) ultrasound.

5. **Clinical Laboratory Service:**

A clinical laboratory service shall have:

a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;

b. capability of collecting and storing blood for emergency care; and

c. clinical laboratory services immediately available.

E. <u>SUPPLEMENTAL SERVICES</u>:

1. In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following <u>approved</u> supplemental services:

a. Burn Center.
   (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if

resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
   (5) Occupational Therapy Service Speech Therapy Service
   (6) Social Service

2. A Trauma Center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
      (1) a pediatric intensive care unit (PICU) approved by the State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
      (2) a multidisciplinary team to manage child abuse and neglect.
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the

California Health and Safety Code.

d. An outreach program, to include:
   (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
   (2) trauma prevention for the general public.

e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. QUALITY IMPROVEMENT PROCESS:

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. VOLUME STANDARDS:

A Level I Trauma Center shall have one of the following patient volumes annually:

1. a minimum of 1200 trauma program center admissions, or

2. a minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is greater than 15, or

3. an average of 35 trauma patients, with an ISS greater than 15, per trauma program surgeon per year.

H. **CLINICAL EDUCATION AND RESEARCH:**

A Level I Trauma Center shall include the following:

1. Trauma research program with ongoing clinical research in trauma.

2. Accreditation Council on Graduate Medical Education (ACGME) approved surgical, internal medicine and anesthesiology residency programs. A mechanism shall be in place to ensure residents' participation in the acute care of the trauma patient.

3. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

4. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS 2005

INTRODUCTION:

Emergency Department Approved for Pediatrics (EDAP) Standards were developed as a concerted effort by the Committee on Pediatric Emergency Medicine, which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians, National EMSC Resource Alliance, California Chapter 2 of the American Academy of Pediatrics, Emergency Nurses Association, American College of Surgeons, and Los Angeles County Department of Health Services Emergency Medical Services Agency.

The Standards have been approved by The Hospital Association of Southern California and meet or exceed the standards established by the Emergency Medical Services for Children (EMSC) administration, personnel, and policy guidelines for the care of pediatric patients in the emergency department set forth by the California Emergency Medical Services Authority in 1995.

DEFINITIONS:

Board certified: Completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in that specialty.

Board prepared: Successful completion of a Board approved emergency medicine or pediatric residency training program and demonstrate active progression in the certifying process.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic emergency department that is approved by the

County of Los Angeles to receive pediatric patients from the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies, procedures, and protocols.

Medical Pediatric Critical Care Center (MPCCC): A licensed acute care hospital that is approved by the County of Los Angeles to receive critically **ill** non-trauma pediatric patients from the 9-1-1 system.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the County of Los Angeles to receive critically **injured** pediatric trauma patients from the 9-1-1 system.

Promptly available: Being in the emergency department within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, that the interval between the arrival of the patient to the emergency department and the arrival of the respondent should not have a measurably harmful effect on the course of patient management or outcome.

Qualified specialist: A physician licensed in the State of California who has: 1) taken special postgraduate medical training, or has met other specified requirements; and 2) active progression towards board certification in the corresponding specialty for those specialties that have board certification and are recognized by the American Board of Medical Specialties.

Senior resident: A physician licensed in the State of California who has completed at least two years of the residency under consideration and has the capability of initiating treatment when the clinical situation demands, and who is in training as a member of the residency program at the designated hospital.

I. ADMINISTRATION/COORDINATION

A. EDAP Medical Director

1. Qualifications:

   a. Qualified specialist in Emergency Medicine or Pediatrics
   b. Completion of eight hours of CME in topics related to pediatrics every two years
   c. Current Pediatric Advanced Life Support Course (PALS) or American Academy of Pediatrics - American College of Emergency Physicians Advanced Pediatric Life Support Course (APLS) provider or instructor

2. Responsibilities:

   a. Oversight of EDAP quality improvement (QI) program
   b. Member of hospital emergency department committee and pediatric committee
   c. Liaison with medical pediatric critical care centers (MPCCC), pediatric trauma centers (PTC), base hospitals, community hospitals, prehospital care providers, and the EMS Agency
   d. Identify needs and facilitate pediatric education for emergency department physicians
   e. Review, approve, and assist in the development of all pediatric policies and procedures

B. Designated Pediatric Consultant *

1. Qualifications:

   a. Qualified specialist in pediatrics or subspecialty in pediatric emergency medicine

2. Responsibilities:

   a. Member of hospital emergency department committee and pediatric committee

b. Participation with EDAP staff in developing and monitoring pediatric QI program, protocols, policies and procedures
c. Consult with EDAP Medical Director and Pediatric Liaison Nurse as needed

* Pediatric Consultant may also be the EDAP Medical Director

C. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years experience in pediatrics or in an emergency department that sees pediatric patients, within the previous five years
b. Experience with QI programs is recommended
c. Current PALS or APLS provider /instructor
d. Completion of a two day pediatric emergency nursing course or ENPC course *
e. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in pediatric topics every two years

2. Responsibilities:

a. Attend monthly meetings of the Pediatric Liaison Nurses of Los Angeles County
b. Participate in the development and maintenance of a pediatric QI program
c. Liaison with MPCCCs, PTCs, base hospitals, community hospitals, prehospital care providers, and the EMS Agency
d. Member of selected hospital based emergency department and/or pediatric committees
e. Notify the EMS Agency in writing of any change in status of the EDAP Medical Director, Pediatric Consultant, and Pediatric Liaison Nurse

* A two day pediatric emergency nursing course should include but not limited to a broad spectrum of topics including: injury prevention, resuscitation, surgical emergencies, apparent life threatening event (ALTE), death of a child to include sudden infant death syndrome (SIDS), trauma, medical conditions, submersions, respiratory emergencies, airway management, ingestion, child abuse and neglect, fever to include bacterial and viral infections, seizures, and neonatal emergencies.

II. PERSONNEL

A. Physicians-Qualifications/Education

1. Twenty four hour emergency department coverage shall be provided or directly supervised by physicians functioning as emergency physicians or pediatricians experienced in emergency care. This includes senior residents practicing at their respective hospitals only.

2. At least 75% of the emergency department coverage shall be provided by physicians who are Board certified or demonstrate active progression in the certifying process towards emergency medicine or pediatrics.

3. Those emergency department physicians who are not board certified or board prepared shall be a current PALS or APLS provider or instructor.

B. Nurses-Qualifications/Education

1. At least 75% of the total RN staff and at least one RN per shift in the emergency department shall be a current PALS or APLS provider or instructor.

2. At least one RN per shift shall have completed a two day pediatric emergency nursing course (within

the last 4 years).

NOTE: It is highly recommended that all nurses regularly assigned to the emergency department meet the above requirements.

3. All nurses assigned to the emergency department shall attend at a minimum; eight hours of pediatric BRN approved education every two years, which may include the two day pediatric emergency nursing course.

C. Pediatric physicians/Specialty services

1. There shall be a pediatric on call panel that allows for telephone consultation and a promptly available pediatrician to the emergency department twenty four hours per day. This pediatrician shall be board certified or board prepared.

2. A plan shall exist whereby other pediatric specialists may be consulted and available in at least the following specialties: surgery, orthopedics, anesthesia and neurosurgery. This requirement may be met by a written agreement with a MPCCC.

3. A plan shall exist whereby a second emergency physician or pediatrician will be available within thirty minutes to serve as back-up for the emergency department in critical situations.

D. Physician Assistant-Qualifications/Education

1. Physician Assistant (PA) licensed by the State of California

2. PA working in the emergency department shall be a current PALS or APLS provider or instructor.

III. POLICIES, PROCEDURES, AND PROTOCOLS

A. Establish procedures and protocols for pediatric emergency patients to include but not limited to:

1. Triage and initial evaluation
2. Patient safety
3. Suspected child abuse and neglect
4. Transfers
5. Consents
6. Sedation/analgesia
7. Do-not-resuscitate (DNR)/Advanced Health Care Directives
8. Death to include SIDS and the care of the grieving family
9. Aeromedical transport to include landing procedure
10. Daily verification of proper location and functioning of equipment and supplies of the pediatric code cart.
11. Immunizations
12. Child abandonment to include a recent (within 72 hours) postpartum woman without evidence of a newborn
13. Family presence

B. Establish a written interfacility consult and transfer agreement with a MPCCC and PTC to facilitate transfers of critically ill and injured pediatric patients. The consult shall be available twenty four hour a day for telephone consultation.

C. Establish a written interfacility consult and transfer agreement with a California Children Services (CCS) approved Level II or Level III Neonatal Intensive Care Unit (NICU).

IV. QUALITY IMPROVEMENT (QI)

A. A pediatric QI program shall be developed and monitored by the EDAP Medical Director and Pediatric Liaison Nurse with input from the Designated Pediatric Consultant as needed.

B. The program should include an interface with prehospital care, emergency department, trauma, pediatric critical care, pediatric in-patient, and hospital wide QI activities.

C. A mechanism shall be established to easily identify pediatric (14 years & under) visits to the emergency department.

D. The pediatric QI program should include identification of the indicators, methods to collect data, results and conclusions, recognition of improvement, action(s) taken, assessment of effectiveness of actions, and communication process for participants.

E. The pediatric QI program should include review of the following pediatric patients seen in the emergency department:

1. Deaths

2. Cardiopulmonary and/or respiratory arrests, including all pediatric intubations

3. Suspected child abuse or neglect

4. Transfers to and/or from another facility

5. Admissions from the ED to an adult ward or ICU

6. Selected return visits to the ED

7. Pediatric transports within the 9-1-1 system

F. A mechanism to document and monitor pediatric education of EDAP staff shall be established.

V. SUPPORT SERVICES

A. Respiratory Therapy

1. At least one respiratory therapist shall be in house twenty four hours per day.

2. Current PALS provider or instructor

B. Radiology

1. Radiologist on call and promptly available twenty four hours per day

2. Radiology technician in house twenty four hours per day with a back up technician on call and promptly available

3. CT scan technician on call and promptly available

C. Laboratory

1. Technician in house twenty four hours per day and a back up technician on call and promptly available

2. Clinical Laboratory capabilities in house:

a. Chemistry
b. Hematology
c. Blood bank
d. Arterial blood gas
e. Microbiology
f. Toxicology
g. Drug levels

NOTE: Toxicology and drug levels may be done offsite if routine tests are available within two hours.

VI. EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. EDAP staff shall be appropriately educated as to the locations of all items. Each EDAP shall have a method of daily verification of proper location and function of equipment and supplies. It is highly recommended that each EDAP have a mobile pediatric crash cart.

The following are requirements for equipment, supplies, and medications for an EDAP:

GENERAL EQUIPMENT

Foley catheters (8-22fr)
IV blood/fluid warmer
Length and weight tape for determining pediatric resuscitation drug dosages
Meconium Aspirator
OB Kit
Posted or readily available pediatric drug dosage reference material calculated on a dose per kilogram basis.
Restraint device
Weight scale in kilograms
Warming device

MONITORING EQUIPMENT

Blood pressure cuffs (infant, child, adult, and thigh)
Doppler
ECG monitor/defibrillator (0-400 Joules) with pediatric and adult paddles
End tidal CO_2 monitor or detector, (adult and pediatric sizes)
Hypothermia thermometer
Pulse oximeter

RESPIRATORY EQUIPMENT

Bag-valve-mask device, self inflating (pediatric size: 450-900ml and adult size: 1000-2000ml)
Bag-valve, with clear masks (neonate, infant, child, and adult sizes)
Endotracheal tubes (uncuffed: 2.5-5.5 and cuffed: 6.0-9.0)
Laryngoscope (curved and straight: 0-3)
Magill forceps (pediatric and adult)
Nasal cannulae (infant, child, and adult)
Nasopharyngeal airways (infant, child, adult)
Nasogastric tubes (including 5 and 8fr feeding tubes)
Oral airways (sizes 0-5)
Clear oxygen masks (standard and non-rebreathing) for infant, child, and adult
Stylets for endotracheal tubes
Suction catheters (sizes 6-12fr)
Tracheostomy tubes (sizes 0-6)
Yankauer suction tips

VASCULAR ACCESS EQUIPMENT

Arm boards (infant, child, and adult)
Infusion devices to regulate rate and volume
Intraosseous needles
IV administration sets with calibrated chambers
IV catheters (14-26ga)
IV solutions (D5.2NS, D5.45NS, D5NS, D10W, and NS)
Stopcocks (3 way)
Umbilical vein catheters

FRACTURE MANAGEMENT DEVICES

Pediatric cervical spine immobilization devices
Pediatric femur splint
Spine board (long and short)

SPECIALIZED TRAYS OR KITS

Cricothyrotomy tray
Pediatric lumbar puncture tray
Pediatric tracheostomy tray
Thoracostomy tray
Chest tube (sizes 10-28fr)
Venous cutdown tray

ATTACHMENT A-1

PEDIATRIC SPECIFIC RESUSCITATION MEDICATIONS

Albuterol	Epinephrine (1:1,000
Amiodarone	& 1:10,000)
Atropine	Lidocaine
Adenosine	Naloxone
Calcium chloride	Procainamide
Dextrose (25% & 50%)	Racemic epinephrine
Dopamine	(inhalation)
Dobutamine	Sodium Bicarbonate

NOTE: It is suggested that these drugs be immediately available in the resuscitation room and not locked in a computerized system.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II
LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II

TRAUMA CENTER REQUIREMENTS

LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response

was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

   (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;

   (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

   (3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has

been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS:**

1. A licensed hospital which has been designated as a Level II Trauma Center by the EMS Agency.

2. Appropriate pediatric equipment and supplies and the capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.

4. ReddiNet System where geographically available.

5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
   a. recommending trauma team physician privileges;
   b. working with nursing and administration to support the needs of trauma patients;
   c. developing trauma treatment protocols;
   d. determining appropriate equipment and supplies for trauma care;
   e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
   f. having authority and accountability for the quality improvement peer review process;
   g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
   h. coordinating pediatric trauma care with other hospital and professional services;

i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.

6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured patient;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
   c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.

9. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists:

a. General Surgery
b. Neurologic
c. Obstetric/Gynecologic
d. Ophthalmologic
e. Oral or Maxillofacial or Head/Neck
f. Orthopaedic
g. Plastic
h. Urologic

10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
    a. Anesthesiology
    b. Emergency Medicine
    c. Internal Medicine
    d. Pathology
    e. Psychiatry
    f. Radiology

11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS:**

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

    a. Immediately Available:
        (1) General surgery:
        A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

        (Requirement may be fulfilled by a supervised

senior resident as defined in Section A-12 of this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available:</u>

(1) Cardiothoracic
(2) General Surgeon *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second general surgeon.)*
(3) Hand
(4) Neurologic *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(5) Obstetric/Gynecologic
(6) Ophthalmic
(7) Oral or Maxillofacial or Head/Neck
(8) Orthopedic
(9) Plastic
(10) Reimplantation/Microsurgery *(This surgical*

service may be provided through a written transfer agreement at Level I and Level II Trauma Centers.)

(11) Urologic

(12) Vascular *(Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:

Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Pediatric
(3) Spinal cord injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

b. Promptly Available:
(1) Anesthesiologist

(Shall be Promptly Available with a mechanism

established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Emergency Medicine (Second physician on call.)
(3) Radiologist

c. Available for Consultation:
(1) Cardiologist
(2) Gastroenterologist
(3) Hematologist
(4) Infectious Disease Specialist
(5) Internist
(6) Nephrologist
(7) Neurologist
(8) Pathologist
(9) Pediatrician
(10) Pulmonary Disease Specialist

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**
Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
a. designate a Medical Director;
b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
c. designate an emergency physician to be a member of the trauma team;

d. provide emergency medical services to adult and pediatric patients;
e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
g. comply with current Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available;
b. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
c. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code. (A Surgical Intensive Care Unit is acceptable.)

3. **Intensive Care Service:**

In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

a. for trauma patients, the ICU's may be separate specialty units;
b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
c. have a qualified specialist promptly available to care for the trauma patients in the intensive care unit. (*The qualified specialist may be a resident with two (2) years of training who is supervised*

by the staff intensivist or attending surgeon who participates in all critical decision making.); and

d. the qualified specialist in (3) above shall be a member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have <u>immediately available</u> a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services <u>promptly available</u>:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:**
   A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available.

E. <u>SUPPLEMENTAL SERVICES</u>:

1. In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following <u>approved</u> supplemental services:
   a. Burn Center.
      (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The

Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
   (5) Occupational Therapy Service Speech Therapy Service
   (6) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
      (1) a pediatric intensive care unit approved by the State Department of Health Services' California Children Services (CCS);or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
      (2) a multidisciplinary team to manage child abuse and neglect.
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:

(1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
(2) trauma prevention for the general public.

e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. **QUALITY IMPROVEMENT PROCESS:**

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. **VOLUME STANDARDS:**

A Level II Trauma Center shall demonstrate the capacity and ability to care for 350 trauma patients annually, including surgical and intensive care unit capacities/capabilities.

H. CLINICAL EDUCATION:

A Level II Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III
PEDIATRIC LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III

TRAUMA CENTER REQUIREMENTS

PEDIATRIC LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a

period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and

c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is <u>board certified</u> in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A <u>non-board certified</u> physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal

College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS:**

1. A licensed hospital which has been designated as a Level I pediatric Trauma Center by the EMS Agency.

2. ReddiNet System where geographically available.

3. A pediatric trauma program medical director who is a board certified pediatric surgeon (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
   a. recommending pediatric trauma team physician privileges;
   b. working with nursing and administration to support the needs of pediatric trauma patients;
   c. developing pediatric trauma treatment protocols;
   d. determining appropriate equipment and supplies for pediatric trauma care;

e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
f. having authority and accountability for the pediatric trauma quality improvement peer review process;
g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
h. coordinating pediatric trauma care with other hospital and professional services;
i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.

4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
   c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
   a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
   b. the remainder of the team shall include physician, nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following <u>non-surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology
   c. Critical Care

d. Emergency Medicine
e. Gastroenterology
f. General Pediatrics
g. Hematology/Oncology
h. Infectious Disease
i. Neonatology
j. Nephrology
k. Neurology
l. Pathology
m. Psychiatry
n. Pulmonology
o. Radiology
p. Rehabilitation/Physical Medicine. (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.)*

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS:**

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:
(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric trauma surgeon with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly available; and
(iii) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u> with pediatric experience:
(1) Cardiothoracic

(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Hand
(4) Pediatric Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(5) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(6) Pediatric Ophthalmic
(7) Pediatric Oral or Maxillofacial or Head/Neck
(8) Pediatric Orthopedic
(9) Plastic Surgeon
(10) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(11) Urologic
(12) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care

shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric *trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)*

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:
(a) a qualified specialist in pediatric emergency medicine; or
(b) a qualified specialist in emergency medicine with pediatric experience; or
(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine with

pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

(2) Pediatric Anesthesiologist:
Pediatric Anesthesiology, Level I shall be immediately available, with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse

anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(3) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

(a) a qualified specialist in pediatric critical care medicine; or

(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or

(c) a qualified surgeon with expertise in pediatric critical care; or

(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:

(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and

(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric

intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:
(1) Pediatric Anesthesiology (second call)
(2) Pediatric Emergency Medicine (second call)
(3) Pediatric Gastroenterology
(4) Pediatric Infectious Disease
(5) Pediatric Nephrology
(6) Pediatric Neurology
(7) Pediatric Pulmonology
(8) Pediatric Radiology

c. Available for Consultation:
(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:
(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology
(e) Pediatric Cardiology
(f) Pediatric Hematology/Oncology
(g) Pediatric Infectious Disease

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement**:
(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with the Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;
b. appropriate surgical equipment and supplies as determined by the trauma program medical director;
c. cardiopulmonary bypass equipment; and
d. operating microscope.

3. **Pediatric Intensive Care Unit (PICU):**

a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS);
b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
c. The pediatric intensive care specialist shall be **immediately available**, advised about all patients who may require admission to the PICU, and shall participate in all major therapeutic decisions and interventions; and
d. The qualified specialist in (c) above shall be a

member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services promptly available for children:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
   a. Burn Center.
      (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if

resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
   (5) Occupational Therapy Service
   (6) Speech Therapy Service
   (7) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code. (Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
      (2) trauma prevention for the general public; and
      (3) public education and illness/injury prevention education.
   e. Written inter-facility transfer agreements with referring and specialty hospitals.
   f. Suspected child abuse and neglect team (SCAN).
   g. Aeromedical transport plan.
   h. Child Life Program.
   i. Pediatric Trauma research program.

j. Maintain an educational rotation with an Accreditation Council on Graduate Medical Education (ACGME) approved and affiliated surgical residency program.

F. **QUALITY IMPROVEMENT PROCESS:**

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. **CLINICAL EDUCATION AND RESEARCH:**

A Level I Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
PEDIATRIC LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
TRAUMA CENTER REQUIREMENTS
PEDIATRIC LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score " or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a

period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and

c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is <u>board certified</u> in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A <u>non-board certified</u> physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal

College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS:**

1. A licensed hospital which has been designated as a Level II pediatric Trauma Center by the EMS Agency.

2. ReddiNet System where geographically available.

3. A pediatric trauma program medical director who is a board certified surgeon with experience in pediatric trauma care (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
   a. recommending pediatric trauma team physician privileges;
   b. working with nursing and administration to support the needs of pediatric trauma patients;
   c. developing pediatric trauma treatment protocols;
   d. determining appropriate equipment and supplies for

pediatric trauma care;

e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
f. having authority and accountability for the pediatric trauma quality improvement peer review process;
g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
h. coordinating pediatric trauma care with other hospital and professional services;
i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.

4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
   c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
   a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
   b. the remainder of the team shall include physician, nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following <u>non-surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology

c. Critical Care
d. Emergency Medicine
e. Gastroenterology
f. General Pediatrics
g. Hematology/Oncology
h. Infectious Disease
i. Neonatology
j. Nephrology
k. Neurology
l. Pathology
m. Psychiatry
n. Pulmonology
o. Radiology
p. Rehabilitation/Physical Medicine (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.)*

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS:**

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:
(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for

consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric *trauma surgeon with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly available; and*
(iii) a staff pediatric trauma surgeon or a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and Promptly Available with pediatric

experience:

(1) Cardiothoracic
(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(4) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(5) Ophthalmic
(6) Oral or Maxillofacial or Head/Neck
(7) Orthopedic
(8) Plastic
(9) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(10) Urologic
(11) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
(b) a staff trauma surgeon or a staff

surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric *trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)*

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:
(a) a qualified specialist in pediatric emergency medicine; or
(b) a qualified specialist in emergency medicine with pediatric experience; or
(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education

in pediatric emergency medicine with pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

(2) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

(a) a qualified specialist in pediatric

critical care medicine; or

(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or

(c) a qualified surgeon with expertise in pediatric critical care; or

(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:

(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and

(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:

(1) Anesthesiologist:
Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who

are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Radiologist

c. Available for Consultation:

(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:

(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology
(e) Pediatric Cardiology
(f) Pediatric Gastroenterology
(g) Pediatric Hematology/Oncology
(h) Pediatric Infectious Disease
(i) Pediatric Neurology
(j) Pediatric Radiology

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement**:

(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics;
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available; and
b. appropriate surgical equipment and supplies as determined by the trauma program medical director.

3. **Pediatric Intensive Care Unit (PICU):**

a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS);
b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
c. The pediatric intensive care specialist shall be **promptly available** to care for trauma patients in the intensive care unit; and
d. The qualified specialist in (c) above shall be a member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services promptly available for children:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
   a. Burn Center.
      (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating

the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
   (1) Physical Therapy Service
   (2) Rehabilitation Center (*(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
   (5) Occupational Therapy Service
   (6) Speech Therapy Service
   (7) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code.(Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
      (2) trauma prevention for the general public; and
      (3) public education and illness/injury prevention education.
   e. Written inter-facility transfer agreements with referring and specialty hospitals.
   f. Suspected child abuse and neglect team (SCAN).
   g. An aeromedical transport plan.
   h. A Child Life Program.

F. <u>QUALITY IMPROVEMENT PROCESS</u>:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. <u>CLINICAL EDUCATION AND RESEARCH</u>:

A Level II Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;

d. EMS personnel; and
e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B
PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B
PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE INDIGENT CARE FUNDING

A. GENERAL REIMBURSEMENT CONDITIONS: County has allocated certain monies as set forth herein to be used to pay Contractor for trauma care provided by them to eligible patients during the term of this Agreement. For the term of this Agreement, funds and Hospital Services Account funds shall be deposited to the County administered Special Revenue Funds referenced in Paragraph I.D.2. of Exhibit B. These deposits, together with other funds which County may at its sole discretion allocate to the account from time to time, and any interest which the deposits may earn, shall be used to pay Contractor for trauma patient care.

Reimbursement to Contractor shall be provided from the Special Revenue Funds by County for the hospital component of treatment of trauma patients hereunder who are unable to pay for the treatment and for whom payment for such services has not been made and will not be made through private coverage or by any program funded in whole or in part by the federal government.

Contractor will determine and document persons who are eligible for services coverage hereunder. Only eligible patients (i.e., (1) those unable to pay for services, and (2) for whom there is no third-party coverage in part or in whole for trauma

services provided) qualify under this funding program. No reimbursement shall be provided for patient care if the patient has the ability to pay for the service, but refuses or fails to pay for same. Nor is County responsible nor shall it pay for services hereunder if Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s). Nor shall reimbursement be due Contractor or paid by County hereunder for any patient care which is covered in, or the subject of reimbursement in, any other contract between Contractor and County.

To bill County, Contractor must at a minimum show that it has made reasonable efforts to secure payment from the patient by billing (at least monthly) for an additional period of not less than two (2) months after the date Contractor first billed the patient. Contractor must show that the person cannot afford to pay for the services provided by the Contractor; and, it must also show that payment for the services will not be covered by third-party coverage or by any program funded in whole or in part by the federal government; and, that Contractor has not received payment for any portion of the amount billed.

County reimbursement is limited to trauma patients without

the ability to pay for the services and for whom Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, and there is no source of payment.

Contractor will continue to determine and document persons who are eligible for trauma care coverage hereunder in accordance with the procedures set forth in Attachment "B-1", Trauma Service County Eligibility ("TSCE") Protocol, attached hereto and incorporated herein by reference.

Attachment "U-1", Trauma Service County Eligibility ("TSCE") Agreement form shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s). If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative(s) is (are) unable to cooperate in providing the necessary financial information, then a Contractor certification to that effect (Attachment "U-2", Hospital Certification of Inability to Cooperate form) must be completed. The original of each such form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the

applicable form to the County Emergency Medical Services (EMS) Agency as stated in Attachment "B-4", Instructions for Submission of Claims and Data Collection.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request, pursuant to Paragraph 5. of the Additional Provisions Exhibit of this Agreement, to authorized County or State representatives for inspection, audit, and photocopying.

During the term of this Agreement, as required by section 16818 of the Welfare and Institutions Code, Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care under this Agreement. Additionally, Contractor shall post throughout such period, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care hereunder. The language which must be used in such individual and public notices shall follow that prescribed by the State of California and as it may be revised from time to time. The State's currently approved "Notice" language is reflected in English in Attachment "B-2" and in Spanish in Attachment "B-3".

B. CONTINUED BILLING TO COUNTY: In the event funding as set forth in Paragraph I.D. of Exhibit B is exhausted prior to the expiration or other termination of this Agreement, Contractor shall continue to bill County, for remaining period up to such expiration or earlier termination, in accordance with the terms of this Agreement.

C. PAYMENT FOR CONTRACTOR SERVICES:

1. County agrees under the following conditions to reimburse Contractor for the hospital component of trauma services to eligible trauma patients described in Paragraph I.A. of Exhibit B, within forty-five (45) days of receipt of a valid claim:

a. Reimbursement by County shall be limited to payment for the hospital component of trauma services provided to eligible indigent trauma patients for whom Contractor is required to complete a Trauma Patient Summary ("TPS") form, Attachment "D-2", of Agreement.

b. Contractor shall submit required reports as set forth in Attachment "B-4", Instructions for Submission of Claims and Data Collection, attached hereto and incorporated herein by reference to County's Emergency Medical Services Agency, 5555 Ferguson Drive,

Suite 220, Commerce, California 90022, for trauma care provided under the terms of this Agreement, and this care shall be reimbursed by County pursuant to subparagraphs I.C.1.d.and f. of Exhibit B.

c. Reimbursement by County shall be limited to the hospital component of trauma services provided to eligible indigent patients during the term of this Agreement. Reimbursement shall only be made on claims for which all required data is in the TEMIS and which has been submitted as required by reporting procedures reflected in Attachment "B-4". Reimbursement to Contractor and other County contract trauma service hospitals shall be made from the Special Revenue Funds (see infra.). All Contractor claims for reimbursement must be received by County within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

d. Following receipt of all of the required reports and billings from Contractor and other contract trauma service hospitals and subject to the funding provision below, County payment hereunder for the

hospital component of trauma services provided by Contractor to eligible trauma patients, as defined hereunder, shall be based on the following all-inclusive rates:

FY 2006-07	FY 2007-08	
$5,100	$ 5,508	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$9,900	$10,692	for the first inpatient day; and
$4,300	$ 4,644	for the second inpatient day; and
$3,400	$ 3,672	for the third inpatient day; and
$3,400	$ 3,672	for the fourth inpatient day;and
$2,400	$ 2,592	for each day thereafter.

These payments will be the maximum amounts payable to Contractor for care hereunder, with aggregate payment for all Contractors for services provided during the term of this Agreement until the funds set forth in Paragraph I.D. of Exhibit B are exhausted.

e. Once the medical condition of a trauma

patient has stabilized, Contractor may contact the County's Medical Alert Center or other personnel as designated by County to request transfer of the trauma patient in accordance with County patient transfer procedures and priority criteria as approved by Director. Until the transfer occurs, County's responsibility for reimbursement to Contractor for medically necessary services shall continue as described herein.

f. Any and all payments received by Contractor from a trauma patient or from third-party payers, or both, for claims previously billed to the County, must be immediately reported to the County. If Contractor previously received payment from the County for such claims, the Contractor must immediately submit a refund of County's payment to the Department of Health Services Special Revenue Funds Section, 313 North Figueroa Street, Room 531, Los Angeles, California 90012. A TRAUMA HOSPITAL PAYMENT REFUND FORM (Attachment B-6) must be completed and submitted for each refund. All such refunds received by County will be deposited to the Special Revenue Funds. If Contractor has not received

payment from the County for such claims, the Contractor must withdraw the claim by notifying the EMS Agency Reimbursement Coordinator at 5555 Ferguson Drive, Suite 220, Commerce, California 90022.

g. Director, at his/her discretion, may deduct from payments due to Contractor any prior overpayments made under this Agreement which were paid due to County's or to Contractor's clerical error or which resulted from Contractor's subsequent receipt of payment from the patient or third-party payer(s). County shall furnish Contractor with an itemization of such deductions, which will include the identity of the patient(s) for whose care overpayment was made, amounts of overpayment, and the basis for the finding of overpayment.

h. Upon payment of claim to Contractor by County for a trauma patient's care, and assignment and subrogation to County of any and all rights to collection as set forth herein, Contractor shall within 90 days of the receipt of those funds, cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from

the patient.

Contractor shall pursue reimbursement from third party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance if they become aware of coverage. Contractor shall, upon verification of such third party coverage, submit a bill for its services to the third party. As soon as payment is received, Contractor shall reimburse County any payment received under the Trauma Center Service Agreement (TCSA) for that patient. Contractor agrees to assign and subrogate all rights that they may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Contractor for which a claim has been paid by County under the TCSA. At its sole discretion, County and/or its Contractor may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees, (including, for example, billed charges) for patient care and services

regardless of any amount the Contractor has received under the TCSA. In the event Contractor is contacted by other third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation, Contractor shall indicate that the paid claim for services provided to their client is assigned and subrogated to the County and refer such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses.

For trauma patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement, and remaining in the hospital after that date, reports and billings to County shall be submitted only after patient has been discharged in the subsequent fiscal year (no partial billings). Payment by County to Contractor for such patients shall be at the rates in

effect on the date of admission. Said reports and billings shall be on forms, and completed in such detail and with such attachments in accordance with procedures prescribed in writing by Director in Attachment "B-4".

Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Said reports shall be submitted to County's EMS Agency no later than within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

i. Any funds received by the County, pursuant to Paragraph I.C.1.h., shall be deposited into the Special Revenue Funds.

2. All required reports and billings submitted by Contractor shall be rendered in the name of Contractor as said name appears upon the upper portion of the first page of this Agreement.

3. Contractor shall maintain and make available to State or County representatives upon request records of all of the financial information referenced in this Paragraph, including records of patient and third-party payer payments, all in accordance with Paragraph 5. of the Additional

Provisions exhibit of the Agreement.

4. County may periodically conduct an audit of the Contractor's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collection agency reports associated with the sampled claims.

Audited paid claims that do not comply with program requirements shall result in a refund to the Special Revenue Funds. The dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of paid claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims resulting in a final refund to the Special Revenue Funds. Contractor may appeal the findings and request an expanded sample, no more than two times of the number the original

sample, if the exception rate exceeds six per cent (6%). The final exception rate, when Contractor has requested an expanded sample, shall be an average of the two findings and shall be applied to the total universe of paid claims.

Audited unpaid claims that do not comply with program requirements shall result in an adjustment in hospital's subsequent year's recommendations for Medi-Cal funding.

D. CLAIMS-BASED FUNDING: The parties have agreed to the following payment mechanisms for payment to the Contractors, with the maximum funding amount as set forth below to apply to the aggregate of payments made to the Contractor under the terms herein, and to payments made to all other trauma hospital Contractors under the terms of identical agreements with the County:

1. a. Funding (Claims Based) for FY 2006-07: County has allocated a maximum total amount of $12.1 million.

b. Funding (Claims Based) for FY 2007-08: Except as set forth below, County has allocated a maximum total amount of $12.1 million. The parties acknowledge that this funding is comprised in part by revenue generated by Measure B Trauma Property

Assessment (TPA) Funds as allocated by the County Board of Supervisors. The parties further acknowledge that the Measure B TPA Funds may vary based on (1) a percentage change, if any, in the total revenue generated for FY 2007-08 as compared to FY 2006-07 (the base year); and (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $12.1 million, taking into account a Measure B Adjustment to the Measure B TPA Funds.

2. Funds and refunds shall be deposited to the County contract trauma hospitals Special Revenue Funds and utilized to make payments to all County contract trauma service hospitals at the rates set forth in subparagraph I.C.1.d. of Exhibit B.

3. All County contract trauma hospitals shall be paid on a first come, first validated, basis until all funds are disbursed. All funds, including interest, shall be disbursed

within forty-five (45) days of receipt of validated claims received by County for Contractor services performed hereunder during the term of this Agreement, all pursuant to the rate schedule identified in subparagraph I.C.1.d. of Exhibit B.

4. "Claims" for purposes of the above means validated claims at the rate defined herein. In no event, however, shall the total disbursement under this Paragraph to Contractor on a claim exceed Contractor's aggregate charges for the services provided (based upon Contractor's customary rates in effect on the dates of service).

5. Maximum amounts payable hereunder to each Contractor shall not be modified if, and upon, designation of any other trauma center not a Contractor hereunder.

E. BILLING AND PAYMENT - PHYSICIAN SERVICES: A copy of the revised Trauma Physician Services Program packet for County Fiscal Year 2006-07, Attachment "B-5 ", is attached and incorporated herein by reference. The packet for future Fiscal Years shall be provided to Contractor as soon as available thereafter. To permit its physicians to bill County for the professional component of un-reimbursed trauma services furnished to Contractor's trauma patients during the term of this

Agreement, Contractor shall furnish members of its physician staff providing such services with a copy of said packet.

Upon request, Director shall provide Contractor with reports showing total aggregate payments to trauma physicians reimbursed by County for the professional component of un-reimbursed trauma services provided to Contractor during the term of this Agreement.

F. RECOVERY OF PAYMENT: County shall recover monies paid to Contractor hereunder for any of the reasons which follow:

1. Contractor fails to furnish patient specific data and reports required by this Agreement or by the State, or by both. County shall recover all funds paid to Contractor for that patient.

2. Funds are used for patients deemed ineligible under this Agreement. County shall recover all amounts paid to Contractor for such patients.

3. Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s). County shall recover all amounts paid to Contractor for that patient.

4. Contractor had knowledge of a third party

tortfeasor and failed to file a lien against such third party. County shall recover all amounts paid to Contractor for such patients, except as set forth in Paragraph I.C.1.h. of Exhibit B.

5. Any funds recovered by the County pursuant to Paragraph I.F. shall be deposited into the Special Revenue Funds.

II. FUNDING FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

The parties acknowledge that a State Plan Amendment (SPA) effective July 1, 2003, was approved by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services. The SPA enables Los Angeles County to receive enhanced Federal Medi-Cal matching funds upon payment by the County of an intergovernmental transfer of funds (IGT) pursuant to section 14087.3 of the Welfare and Institutions Code. Pursuant to the SPA and a related interagency agreement between the County and the California Department of Health Services (CDHS), the IGT and Federal matching funds are distributed among the County-designated trauma hospitals to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County.

EXHIBIT B

Except for UCLA Medical Center, it is the intent of the County, and the County shall recommend to the State, that the funding to each trauma hospital be based on data regarding each hospital's actual trauma center losses, in accordance with the terms and conditions set forth in a separate agreement between the trauma hospital and the State, or its intermediary.

Due to its status as a public institution, UCLA Medical Center shall not receive Federal matching funds, and the County shall instead provide directly to UCLA Medical Center any funding allocation as described herein (with payments made at or about the same time that the other trauma hospitals receive the IGT and Federal matching funds):

A. For Fiscal Year 2006-07, the total County maximum obligation shall be $16.7 million, funded in whole or in part by Measure B funds. The following funding allocation shall be the basis for the County's recommendation to the State for allocation of the IGT and Federal matching Medi-Cal funds:

Children's Hospital	$ 250,000
All other trauma hospitals	$ 16,450,000

Except for the funding allocation to UCLA Medical Center, the total of the funding allocations above shall comprise the IGT for FY 2006-07, which will enable the County-designated trauma hospitals to receive Federal matching funds in approximately the same amount, dollar for dollar. The County shall recommend to the State that the IGT and Federal matching funds be divided among all Contractor trauma hospitals according to trauma center losses as described above.

B. For Fiscal Year 2007-08, the total County maximum obligation shall be $16.7 million, funded in whole or in part by Measure B funds. The following funding allocation shall be the basis for the County's recommendation to the State for allocation of the IGT and Federal matching funds:

Children's Hospital	$ 250,000
All other trauma hospitals	$ 16,450,000

The parties acknowledge that the above amounts are funded in part by Measure B TPA Funds as described

above, and that this aggregate amount for FY 2007-08 may increase based on a Measure B Adjustment if any (with distribution of any additional funds as a result of a Measure B Adjustment on a pro rata basis).

Except for the funding allocation to UCLA Medical Center, the total of the funding allocations above shall comprise the IGT for FY 2007-08, which will enable the County-designated trauma hospitals to receive Federal matching funds in approximately the same amount, dollar for dollar. The County shall recommend to the State that the IGT and Federal matching funds be divided among all Contractor trauma hospitals according to trauma center losses as described above.

III. FUNDING FOR BASE HOSPITAL SERVICES FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES:

To account for the special costs incurred for those Contractors providing base hospital services (Children's Hospital is not providing base hospital services), and to ensure continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients

to the most appropriate emergency room, the County has allocated funding for each such hospital.

It is the intent of the County to obtain Federal matching funding for each County-designated trauma center providing base hospital services, except for UCLA Medical Center, through the SPA as described above.

Due to its status as a public institution, UCLA Medical Center shall not receive Federal matching funds, and the County shall instead provide directly to UCLA Medical Center any funding allocation as described herein (with payments made at or about the same time that the other trauma hospitals receive the IGT and Federal matching funds) :

A. For Fiscal Year 2006-07, the total County maximum obligation shall be approximately $2.4 million (approximately $1.9 million for the IGT and $500,000 for UCLA Medical Center). The County shall determine the funding allocation of the IGT and Federal matching funds, as well as the direct payment to UCLA Medical Center, by taking into account call volume for the prior calendar year of service, including Standing Field Treatment Protocols (SFTPs) requiring medical direction (joint runs) and excluding information only

calls for all trauma hospitals providing base hospital services, as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 1,500 calls/month	$ 428,822
1,501 to 3,000 calls/month	$ 522,546
Over 3,000 calls/month	$ 616,274

The County shall recommend to the State that the IGT and the Federal matching funding be divided as follows, with payment made on or about January of the applicable fiscal year.

CONTRACTOR	MAXIMUM AMOUNT
California Hospital Medical Center	$ 428,822
Cedars-Sinai Medical Center	$ 428,822
Providence Holy Cross Medical Center	$ 428,822
Huntington Memorial Medical Center	$ 428,822
Henry Mayo Newhall Memorial	$ 428,822
Long Beach Memorial Medical Center	$ 428,822
Northridge Hospital Medical Center	$ 428,822
St. Francis Medical Center	$ 428,822
St. Mary Medical Center	$ 428,822

The County shall provide the following directly to UCLA Medical Center:

CONTRACTOR	MAXIMUM AMOUNT
UCLA Medical Center	$ 428,822

B. For Fiscal Year 2007-08, the total County maximum obligation shall be approximately $2.4 million (approximately $1.9 million for the IGT and $500,000 for UCLA Medical Center). The County shall determine the funding allocation of the IGT and Federal matching funds, as well as the direct payment to UCLA Medical Center, by taking into account call volume for the prior calendar year of service, including Standing Field Treatment Protocols (SFTPs) requiring medical direction (joint runs) and excluding information only calls for all trauma hospitals providing base hospital services, as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 1,500 calls/month	$ 428,822
1,501 to 3,000 calls/month	$ 522,546
Over 3,000 calls/month	$ 616,274

Except for UCLA Medical Center, the parties acknowledge that the funding allocations to be determined according to each trauma hospital's call volume shall be comprised of 50% of IGT and 50% of Federal matching funds. If it is determined that the

call volume for any or all of the trauma hospitals has increased such that the maximum amount to be paid exceeds the maximum county obligation as set forth above, the Department shall seek approval from the Board of Supervisors for additional funding as needed.

ATTACHMENT B-1

TRAUMA CENTER SERVICE AGREEMENT

TRAUMA SERVICE COUNTY ELIGIBILITY PROTOCOL

I. PURPOSE: The Trauma Service County Eligibility (TSCE) Protocol is to be used by the County of Los Angeles (County) and by County Contract Trauma Service Hospitals (Contractor) in connection with the Trauma Service Hospital Agreement between the County and Contractor for the purposes of adjusting hospital and other health care charges to Trauma Service Patients for Authorized Services according to the financial conditions of the patient and the patient's responsible relatives.

TSCE shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2 to recover from third-party tort-feasors the reasonable cost of health care services provided to the patients involved.

II. DEFINITIONS:

A. "County Hospital(s)" means any hospital or other health care facility which is owned and operated by the County of Los Angeles.

B. "General Relief recipient(s)" means any person who has

been determined eligible for the County's General Relief program as administered by the County Department of Public Social Services (DPSS).

C. "Inpatient service(s)" means any preventive, diagnostic, or treatment service(s) provided by Contractor to a patient who is a registered inpatient therein.

D. "Inpatient stay of admission " means an uninterrupted term of inpatient services and shall constitute an occurrence of inpatient services.

E. "Emergency Department visit" means any health care services, other than inpatient services, provided in the emergency department by Contractor.

F. "Responsible relative(s)" means the patient's spouse, or parent(s), or legal guardian(s) if the patient is a minor child, or other legal representatives if known.

G. "Special medical payment program(s)" means any program such as Medi-Cal, Medicare, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), California Children Services, and Victims of Crime, which is governed by particular statue, ordinance, or

regulation.

H. "Third-party coverage" means any health care benefits payable on behalf of the patient from other than the financial resources of the patient and the patient's responsible relatives, if any. Generally, third-party coverage includes special medical payment programs, prepaid health plans, and private health insurance.

I. "Trauma Hospital Authorized Service(s)" means any emergency department visits and inpatient services: (1) which have been specifically authorized by the County pursuant to a Trauma Service Hospital Agreement between the County and Contractor, and (2) for which such Contractor may receive reimbursement from the County under such Agreement.

J. "Trauma Patient" means any patient who receives Trauma Hospital Authorized Service.

K. "Trauma Service Hospital(s)" means any hospital or other health facility which is not a County Hospital and which has formally executed a Trauma Service Hospital Agreement with the County under which such hospital or other health care facility may receive

reimbursement from the County for Trauma Hospital Authorized Services provided to trauma patients.

III. SERVICES COVERED: TSCE shall cover any occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit) at any Trauma Service Hospital except for any such occurrence of service for which there is third-party coverage that will fully pay for the particular occurrence of service.

IV. ELIGIBILITY: In order to be eligible for TSCE for inpatient services or for emergency department visits, the patient and the patient's responsible relatives, if any, must cooperate with the County and Contractor in terms of financial data acquisition and otherwise in accordance with TSCE, including, but not necessarily limited to, the following requirements:

A. provide the names and addresses of the patient and the patient's responsible relatives.

B. provide acceptable address verification.

C. complete and sign, under penalty of perjury, the TSCE Agreement, which shall be substantially similar to Attachment U-1, attached hereto and incorporated herein

by reference, setting forth, among other things, the income and family size of the patient and the patient's responsible relatives, and the patient's third party coverage, including, but not limited to, prepaid health plan status (member or not). A separate TSCE Agreement shall be completed and signed for each inpatient stay of admission and for each emergency department visit.

D. complete and sign authorization(s) as requested by the County and the Contractor to allow the County and the Contractor to verify any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

E. provide the County or the Contractor with any documentation requested by the County or the Contractor for any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

V. ELIGIBILITY DETERMINATIONS WHEN PATIENT UNABLE TO COOPERATE: The parties recognize that there may be situations when the patient and/or patient's responsible relatives, if any, are unable to cooperate with the County and the Contractor in

terms of providing the financial information necessary to make a TSCE determination. Examples of these situations include, but are not necessarily limited to, situations where the patient has expired, or is comatose or otherwise mentally incompetent.

Under these circumstances, the Contractor may certify, under penalty of perjury, that it has endeavored to:

A. obtain the names and addresses of the patient and the patient's responsible relatives;

B. obtain acceptable address verification; and

C. obtain all of the information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and the patient's responsible relatives, and the patient's third-party coverage.

This certification by the Contractor which shall be substantially similar to Attachment U-2, attached hereto and incorporated by reference, shall be accepted by the County in lieu of a TSCE Agreement completed by the patient or patient's responsible relatives.

VI. FREQUENCY OF TSCE DETERMINATIONS: TSCE determination, as to

the patient's eligibility for TSCE, shall be subject to the TSCE Agreement (Attachment U-1) and shall establish eligibility for all inpatient services received at a Trauma Service Hospital during an inpatient stay of admission or for health care services received at the said hospital during an emergency department visit.

VII. TSCE ELIGIBILITY COMPUTATION: The patient's TSCE eligibility shall be established by comparing the gross monthly and annual income of the patient and patient's responsible relatives, if any, and the patient's family size to 200 per cent of the Poverty Income Guidelines as published annually in the Federal Register. If the gross monthly and annual income of the patient and the patient's responsible relatives is less than or equal to 200 per cent of the Poverty Guidelines for the patient's family size, then the patient shall be eligible for TSCE and shall not be liable for the inpatient services received during the particular inpatient stay of admission or for health care services received during the particular emergency department visit.

Any patient who is a verified County General Relief recipient shall automatically by granted TSCE eligibility.

Once TSCE eligibility has been established for an occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit), it shall not be re-determined retroactively for any reason except where:

A. The patient and/or the patient's responsible relatives have intentionally failed to fully disclose or have intentionally misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the liability of the patient and the patient's responsible relatives shall, at the election of the Director, revert to the full charge for such occurrence of Trauma Hospital Authorized Service; or

B. Clerical error has occurred or the patient and/or the patient's responsible relatives have negligently failed to fully disclose or have negligently misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the TSCE eligibility shall be re-determined.

C. The patient is determined by the Director not to be

eligible as a Trauma Patient for such occurrence of Trauma Hospital Authorized Service, in which case: (1) the patient and the patient's responsible relatives shall not be eligible for TSCE for such occurrence of service, and (2) any funds received by the particular Contractor from the County for such occurrence of service must be repaid to the County. When a patient and/or patient's responsible relatives, if any, previously unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make TSCE determination, agrees to cooperate, TSCE eligibility shall be re-determined.

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY IS RECEIVING FUNDING AS A RESULT OF PROPOSITION 99 - THE TOBACCO TAX AND HEALTH PROTECTION ACT OF 1988. THESE FUNDS ARE TO BE USED FOR THE PROVISION OF SERVICES FREE OF AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OF BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (323) 890-7521.

NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL ESTA RECIBIENDO FONDOS COMO RESULTADO DE LA PROPOSICION 99 - IMPUESTO SOBRE EL TABACO Y ACTA DE PROTECCION DE SALUD DE 1988. ESTOS FONDOS SON PARA SER USADOS EN PROVEER SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED TIENE QUE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PRGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL SECTOR

COUNTY OF LOS ANGELES ! DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR
SUBMISSION OF CLAIMS AND DATA COLLECTION

! ! ! Revised for Fiscal Year 2006/07! ! !

GENERAL INFORMATION

Physicians must submit both a **HCFA-1500 Form** and a **CHIP Form** for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. **An original CHIP form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

MEDI-CAL ELIGIBILITY: Procedures continue to be in place to run all FY 2006/07 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal.

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **PSIP CLAIMS**
Contact: AIA Physician Hotline - (800) 303-5242

COMPLETION OF CHIP FORM

PATIENT INFORMATION (Items #1-10)

1. TPS #

   Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

   Enter Patient's social security number. Failure to provide the social security number must be justified in item # 26 (REASON) of the CHIP Form.

3. PATIENT'S NAME

   Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

   Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

   Enter Patient's mother's maiden name.

6. ETHNICITY

   Check appropriate box to indicate Patient's racial/ethnic background:

   (1) white
   (2) black
   (3) asian/pacific islander
   (4) native american/eskimo/aleut
   (5) hispanic
   (6) filipino
   (7) other (or none of the above)

7. EMPLOYMENT TYPE

   Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner:

   (0) unemployed
   (1) farming/forestry/fishing
   (2) laborers/helpers/craft/inspection/repair/production/transportation
   (3) sales/service

(4) executive/administrative/managerial/professional/technical/related support
(5) other

*** Note: **Employment type must be consistent with required employment information provided on the HCFA-1500. Claims with inconsistent information will be rejected.**

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty members of the military who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following family members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

*** **Note: For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, submitting physician/agency is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information from the hospital.

*** **Note:** **N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment (OUTPATIENT/OFFICE VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

27. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, enter a signature of the physician/submitting agency attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** -trauma care provided at the following hospitals:

California Hospital Medical Center
Cedars-Sinai Medical Center
Childrens Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center
Other hospitals as approved by the Board of Supervisors and designated by the EMS Agency

(2) **NON-CONTRACT EMERGENCY** - all emergency services provided by a licensed Physician excluding specialty care provided by a designated contract trauma hospital as per (1) above.

(3) **PEDIATRICS** - pediatric services means all medical services rendered by any licensed Physician to persons from birth to 21 years of age, and shall include attendance at labor and delivery.

(4) **OBSTETRICS** - obstetric services means the diagnosis of pregnancy and all other medical services provided by a licensed Physician to a pregnant woman during her pregnancy from the time of conception until 90 days following the end of the month in which the pregnancy ends.

*** **Note:** **If "Obstetrics" is checked, the Expected Date of Delivery (EDD) must be entered.**

21. SERVICE SETTING
Check one of the following:

(1) inpatient
(2) emergency department
(3) outpatient/office visit, CHECK ONE OF: (a) primary care (b) specialty care

*** **Note:** **If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot indicate "N/A" (not available) unless a reasonable justification is indicated in item #26 (REASON).**

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

Enter payee name, address, and nine (9) digit federal tax ID number.

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF HCFA-1500 FORM

The following HCFA-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

*** **Note:** **All employment information must be consistent with CHIP Form, item #7(EMPLOYMENT TYPE).**

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

*** **Note:** **Hospital admit and discharge dates that are equal (i.e., 07-01-06 to 07-01-06) in box 18 must have an explanation in box 19 (Reserved for Local Use)**

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other,* will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another HCFA-1500 form.

F:\USER\JIMMY\AB75\05/06PHYS.INS

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)

FOR EMS USE ONLY
TRAUMA YES ☐
NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-1500

1. TPS #: _____ 2. SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐

3. PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

4. PLACE OF BIRTH: _____
CITY STATE COUNTRY

5. MOTHER'S MAIDEN NAME: _____

6. ETHNICITY: (CHECK ONE)
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN/PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN/ESKIMO/ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

7. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARMING/FORESTRY/FISHING
☐ (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
☐ (3) SALES/SERVICE
☐ (4) EXECUTIVE ADMINISTRATIVE/MANAGERIAL/ PROFESSIONAL/TECHNICAL/RELATED SUPPORT
☐ (5) OTHER

8: MONTHLY INCOME: $ _____ 9. FAMILY SIZE (COUNT PATIENT AS 1): _____

10. SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIRED
☐ (6) OTHER, e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/DIVIDENDS/RENT/ CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

*IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON(S): _____ (26)

SIGNATURE: _____ (27)

PHYSICIAN SERVICES

20. PHYSICIAN FUND:
☐ (1) CONTRACT TRAUMA
☐ (2) NON-CONTRACT EMERGENCY
☐ (3) PEDIATRICS
☐ (4) OBSTETRICS EDD: ☐☐☐

21. SERVICE SETTING:
☐ (1) INPATIENT
☐ (2) EMERGENCY DEPARTMENT
☐ (3) OUTPATIENT/OFFICE VISIT, CHECK ONE OF: ☐ a. PRIMARY CARE ☐ b. SPECIALTY CARE

22. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

23. PAYEE NAME: _____ PAYEE TAX ID#: _____

PAYEE ADDRESS: _____

24. DATE BILLED COUNTY: ☐☐☐ CHARGES: $ _____

FOR QUESTIONS REGARDING CLAIM:

25. CONTACT PERSON _____ TELEPHONE NO: ( ) _____

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

! ! ! Revised for Fiscal Year 2006/07! ! !

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, sections 16950 et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2006/07", attached as Exhibit "A" and incorporated herein by reference. The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is only valid for trauma services rendered during the period July 1, 2006 through June 30, 2007.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a current fiscal year Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.

B. Any Physician, **including an emergency department Physician,** who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services
Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: **CHIP** Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2006 and through June 30, 2007. All claims for services provided during the fiscal year 2006/07 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2007. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2007.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 50% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2006/07 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

   American Insurance Administrators (AIA)
   P.O. BOX 2340
   Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County billing therefore, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race,

color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

COUNTY OF LOS ANGELES ! DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

! ! ! Revised for Fiscal Year 2006/07! ! !

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services **ONLY IF** they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will be

considered upon appeal and/or provision of applicable operative and/or pathology reports.

3. Claims determined to be Medi-Cal eligible will be denied.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

I. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the CHIP Form (Item #20). An obstetric claim submitted without the EDD will be rejected.

B. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to "Wet" or "Stat" readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the CHIP Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT

ATTACHMENT B-5

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

FISCAL YEAR 2006/07
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA).
P.O. Box 2340
Bassett, CA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for trauma services provided by him/her at a County contract trauma hospital to trauma patients who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Physician acknowledges receipt of a copy of the "Trauma Physician Services Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2006/07, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the Trauma Physician Services Program. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the or Trauma Physician Services Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

ATTACHMENT B-5

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2006/07

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____) _____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

ATTACHMENT B-6

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT REFUND FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____ TPS#: _____

AMOUNT OF EMS PAYMENT: $_____

AMOUNT OF FACILITY REFUND: $_____

REASON FOR REFUND	**DATE COVERAGE IDENTIFIED**
DUPLICATE (County Payment)	____/____/____
INSURANCE (Health Plan/HMO)	____/____/____
MEDI-CAL	____/____/____
MEDICARE	____/____/____
PATIENT	____/____/____
THIRD PARTY TORTFEASORS	____/____/____
OTHER _____ (Specify)	____/____/____

SUBMITTED BY: _____ **DATE:** ____/____/____

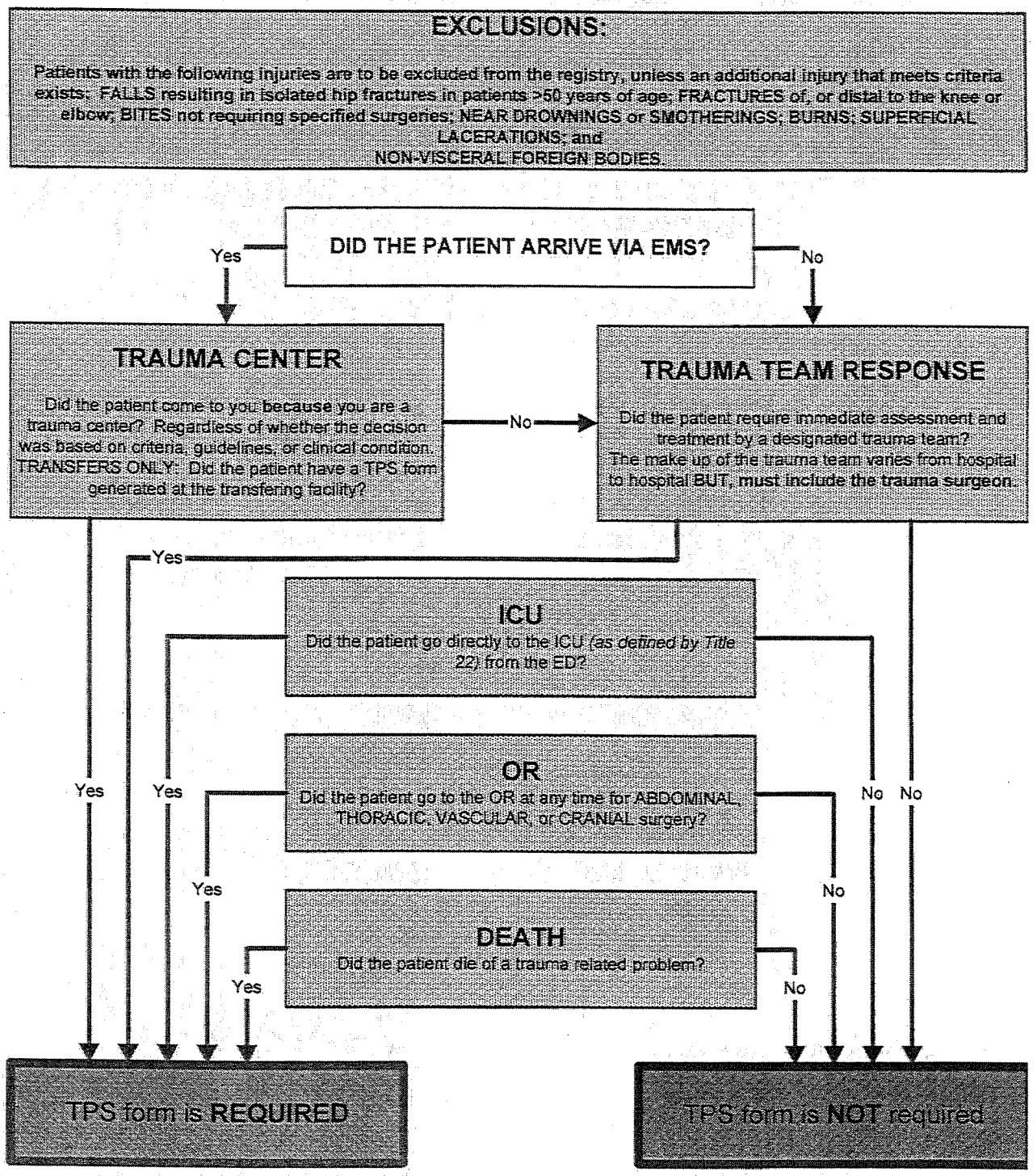
(THIS FORM MUST BE ATTACHED TO EACH REFUND CHECK)
Mail to: SPECIAL REVENUE FUNDS SECTION
313 N. Figueroa St., Room 531
Los Angeles, CA 90012

ATTN: Section Head

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "OTHER *TRAUMA CENTER* DECISION" INDICATED.

INITIAL PATIENT INFORMATION, (TO INCLUDE PATIENT NAME, ADMIT DATE, MODE OF ENTRY, AND SEQUENCE NUMBER) FROM THE TRAUMA PATEINT SUMMARY PAGE ONE (TPS1) SHALL BE ENTERED INTO THE TEMIS DATABASE WITHIN FIFTEEN (15) DAYS OF HOSPITAL ADMISSION. THE REMAINDER OF TPS1 SHALL BE COMPLETED AND ENTERED INTO THE TEMIS DATABASE WITHIN THIRTY (30) DAYS OF HOSPITAL ADMISSION. TRAUMA PATIENT SUMMARY PAGE TWO (TPS2) SHALL BE COMPLETED AND ENTERED INTO THE TEMIS DATABASE WITHIN SIXTY (60) DAYS OF HOSPITAL DISCHARGE..

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT D

TRAUMA CENTER DATA COLLECTION SYSTEM

1. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY) INCLUDE THE FOLLOWING:

A. The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care.

(1) The system shall include the collection of both prehospital and hospital patient care data, as recommended by the Trauma Hospital Advisory Committee (THAC) to the local EMS agency.

(2) Trauma data shall be integrated into the local EMS agency data management system.

(3) County commits to pursue the participation, in the local EMS agency data collection system efforts, of all hospitals receiving trauma patients in accordance with local EMS agencies policies and procedures which are based on Title 22.

(4) County shall generate and distribute periodic reports to all designated Trauma Centers participating in the trauma system on a quarterly basis, to include but not limited to:

(a) system volume report on the total number of patients by trauma center; and

(b) system volume report on the number of pediatric patients versus the number of adult patients by trauma center; and

(c) system volume report on the number of blunt injuries versus the number of penetrating injuries by trauma center; and

(d) system volume report on the mechanism of injury by trauma center.

(5) County shall generate and distribute for the purposes of benchmarking to Contractor quarterly reports on system aggregate data on the following:

(a) Intensive Care Unit (ICU) Length of Stay (LOS); and

(b) Payer Source distribution; and

(c) Injury Severity Score (ISS) distribution with the patient's outcome, lived versus died.

(6) County agrees to honor special request for reports by Contractor to compare hospital specific data elements to the system aggregate data elements within a reasonable agreed upon time period.

B. The Department agrees to provide the following to the

Contractor:

(1) A current Trauma Center TEMIS software training/procedure manual.

(2) Annually a minimum of sixteen (16) hours Trauma and Emergency Medicine Information System (TEMIS) basic software training and twenty-four (24) hours of intermediate/advanced training will be offered, for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic and advanced report generation functions.

   (a) Contractor's need for basic training of new employees will be met without regard to the minimum number of participants within two (2) weeks of Contractor's request.

   (b) Intermediate/advanced training classes to be scheduled monthly, with a specific agenda for standardized education, with a minimum number of two (2) participants, in no less than four (4) hour increments.

   (c) Additional training hours will be made available as needed.

(3) A nonexclusive, nontransferable license to

Contractor to use current software and documentation and any software updates, or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software and documentation for back-up or archive purposes, but such license further gives Contractors no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software or documentation to any other person or entity.

(4) Installation and maintenance of personal computer (PC) peripherals and software meeting specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, for the purpose of Trauma Center data entry and/or data manipulation. The Department will maintain said equipment in fully functioning order until Agreement is terminated or County replaces the equipment. In the event that Agreement is terminated for any reason, the Department shall promptly remove all TEMIS hardware and software and Contractor shall return

to County all TEMIS documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

(5) Unlimited technical support for the TEMIS system provided during normal business hours.

C. County does not warrant that operation of the hardware or software will be uninterrupted or error-free. In the event of a failure, breakdown of the equipment, or errors in software the Department, on behalf of County, shall use reasonable efforts to promptly rectify the software, repair the failure, or replace the defective component. Whenever possible, the Department shall correct a problem in twenty-four (24) hours or less. County shall have no such obligation if the problem(s) is (are) a direct or indirect result of hardware and/or software modifications, or both, made without written approval from Director. County's inability to resolve above issues will result in temporary suspension of Contractor's data obligations.

The foregoing including responsibilities for resolving hardware and software problems are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other

warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information and the like), arising out of the use or inability to use the software or hardware, even if County has been advised of the possibility of such damages.

County does not assume and shall have no liability under this Agreement for failure to repair or replace defective equipment, software, or the corresponding data due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

2. SPECIFIC RESPONSIBILITIES OF CONTRACTOR INCLUDE THE FOLLOWING:

A. Contractor's data collection requirements for patient inclusion in the trauma data base are defined and set forth in Exhibit "C", attached hereto and incorporated herein by reference.

B. Contractor acknowledges receipt of the County Department of Health Services Trauma Patient Summary Form, Attachment "D-2", attached hereto and incorporated herein by reference. Contractor agrees to provide all mandatory data elements from Attachment "D-2" in reporting trauma patient information to the Department, to assist the Department in its data collection effort. In the event that Director determines that the Department's Trauma Patient Summary Form should be modified or that additional data must be collected by Contractor based on recommendations from the Trauma Hospital Advisory Committee (THAC), said request for additional data must first be referred to the EMSC Data Advisory Committee by Director for review and advice. The Department shall estimate the cost impact on Trauma Centers of the request for the modification and shall advise the EMSC. If the request for additional data results in increased costs to Contractor, Contractor may terminate this Agreement

upon giving at least sixty (60) days prior written notice to County.

C. Contractor shall utilize TEMIS application programs and County-owned equipment, or provide their own equipment in accordance with the specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, in a reasonably secure area of the hospital provided by the Contractor. Contractor shall in no way modify the structure or function of the County-owned hardware or software without prior written approval of Director. The hardware and software configuration provided shall be used exclusively for the purposes intended herein. Use of County-owned equipment for any other purpose or for running any other programs or software shall be done only with the express written consent of Director. Contractors shall at all times provide County representative(s) designated by Director with reasonable access to Contractor premises to allow for installation, maintenance, or removal of County-owned property.

D. Contractor shall provide DSL or T1 internet connection for the submission of Contractor's TEMIS data to

County.

E. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software error.

F. If it is reasonably determined by Director that any Contractor repair or replacement of County-owned equipment, or repair or recovery of software or data, to the extent deemed feasible by Director, was necessary due to theft or due to Contractor's negligence, Contractor shall reimburse County for the repair, replacement, or recovery cost at a maximum labor rate of Fifty Dollars ($50) per hour, plus the actual cost of parts and materials.

G. Contractor shall provide all supplies necessary for the ongoing use of the County-owned equipment (e.g. printer cartridges, printer paper, floppy diskettes, etc.).

H. Contractor shall seek telephone assistance from Director, whenever TEMIS operation failure occurs, to

obtain County TEMIS maintenance services as described herein.

I. Contractor shall assign qualified back-up personnel to operate TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel during equipment installation.

J. All software application modules, all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to insure that these confidential products are safeguarded and held in confidence. Such means shall include, but not be limited to: requiring each Contractor employee or agent given access thereto to enter into a written agreement in the same form identified as Attachment "D-3", Hospital Employee Acknowledgement and Confidentiality Agreement Regarding Trauma Center Data Collection Obligations, attached hereto and incorporated herein by reference; disclosing

confidential County products only to employees with a need to know of such confidential County products in order for Contractor to exercise its rights and perform its obligation as a Trauma Center; and refraining from reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

K. Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license.

L. Contractor shall safeguard and protect the County-owned equipment to ensure full operation. No other application software programs shall be operated on County-owned equipment supplied to Contractor, unless specifically approved in writing by Director.

3. RELEASE AND/OR SALE OF TEMIS DATA:

A. The parties acknowledge that the data collection effort was undertaken for the purpose of improving the Los Angeles Trauma System and that the County and participating hospitals have expended significant amounts of time, effort and money to develop data collection systems and data. Accordingly, it is hereby acknowledged and agreed that County will not release or sell any identifiable data to any entity for publication or for any other use whatsoever without first receiving written permission from Contractor, if it is identified, except as otherwise provided by law.

B. Only non-hospital identifiable information resulting from the Trauma and Emergency Medicine Information System (TEMIS) may be sold by County without permission of the hospitals.

C. Seventy-five percent (75%) of the proceeds of the sale of any TEMIS Trauma Center information shall be distributed to the participating hospitals in equal amounts. Said distribution shall be effected by reducing the annual fee by an amount equal to Contractor's share of the sale of proceeds from the previous year.